“We have a lot to tell”

An ethnography of children’s understandings of health and illness in northern Namibia

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Acknowledgements

Where do I start? Thanks be to God my Saviour, my Jehova Jireh. My thesis seeks to break the silence that veils the lives of so many children living in difficult health situations and with illness challenges, by including their stories specifically in a way they saw them fit to be told. They told me, “We have a lot to tell,” and in doing so they showed that they are our country’s Namibia’s - future and set out a new agenda for children’s agency. All my time spent was only the start of much more to come which hopefully will open up discussionsand further research by other ethnographers inspired to take up the plight of children in our beautiful country. I would like to thank wholeheartedly and acknowledge all the participants in my study who tirelessly and bravely came after their full day of school and spent another few hours doing our after-school sessions and activities. It was indeed a “heap of fun.” As the researcher, I learnt more from you than you could imagine. I am also grateful to my second group of participants - the “nurses” and “woodchoppers” - who showed me another dimension of endurance and hope that I would have never experienced, if it was not through ethnography. I was guided by them and helping with the washing under the tree, giving a hand with the carrying and trying to sell some wood was the best. Every time I wanted to give up on the writing of this thesis, my participants’ faces popped up and reminded me that their stories, ideas and visions had to be read by others. *Tangiuneneshomwa longa nuudhiginini*. Thank you so much for all your hard work.

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Abstract

Little is known about children's ideas, understandings and coping mechanisms regarding health and illness in Namibia, where children are greatly valued and engaged in social life, but their perspectives are rarely sought or understood. This thesis uses children's own perspectives as the focal point for examining health and illness in northern Namibia. The study ethnographically investigates the circumstances and practices of twenty-six young participants between the ages of nine and twelve. It explores the connections between agency and care, responsibility, hope and resistance as the children aim to create meaningful, healthy lives for themselves, their families and their communities. The research techniques involved ethnographic fieldwork and participatory methods, including body mapping, drawings, free listing, photographs and health diaries.

In this thesis I argue that children have what I term *multi-layered agency* that helps them to navigate health and illness challenges. Drawing upon Sherry Ortner (2006), James Laidlaw (2000), Michel de Certeau (1984), and others, I reveal how children's agency reflects their individual wills, hopes and modes of resistance, at the same time that it uncovers their relationally constituted responsibilities, duties and identities. It shows that rural communities' strategies regarding wellbeing are not just shaped by adults, but by the lived experiences of individual children. By showing how health and illness are embedded within wider family, community and kinships relationships, as well as unequal socio economic realities and broader cultural understandings of taboo and the body, this thesis demonstrates the wide range of factors that children must navigate in order to live and manoeuvre within the health challenges that they face.

Furthermore, this thesis emphasises that in addressing health challenges, children's involvement matters. The aim of this thesis is therefore to challenge Namibian health authorities, policy makers and broader communities to deepen their understandings of the daily involvement and challenges children face in their agentive roles and responsibilities towards others. The hope is that relevant interventions will be created which might contribute effectively to improved outcomes for children living and experiencing health and illness challenges in the context of the ongoing HIV/AIDS crisis in Namibia and Southern Africa more broadly.

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List of Acronyms and Abbreviations

ACPF	African Child Policy Forum
AIDS	Acquired Immunodeficiency Syndrome
ART	Treatment Centres
ARV	Antiretroviral
AU	African Union
CIHIV	Children infected with HIV/AIDS
DPH	Directorate of Primary Health Care
HIV	Human Immunodeficiency Virus
MGECW	Ministry of Gender Equality and Child Welfare, Namibia
MoHSS	Ministry of Health & Social Services, Namibia
NDHS	Namibia Demographic and Health Survey
NGO	Non-governmental Organisation
NPC	National Planning Commission
NSA	Namibia Statistics Agency
OAU	Organisation of African Unity (since 2001, the African Union)
SWAPO	South West Africa People's Organization
TB	Tuberculosis
UN	United Nations [General Assembly}
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Glossary

Note: The transliteration system from the Oshiwambo language to English follows the most common English practice and conventional procedure in Namibia. Words and names below are commonly written, publicly listed and published in the Namibian - English system.

aanegumbo	blood ties
cuca shop	a local dairy or shop in the village selling household groceries, a gathering place for locals drinking traditional beer
edu	land
eekombo	goats
eemanda	millet storage bins
eengobe	cattle
egumbo	homestead complex
ekonaakonolyopaufupi	in and out [in terms of medical appointments]
ekove	uncultivated land in the *egumbo* where livestock graze
elimba	storeroom for the kitchen
epata	kitchen
epiya	cultivated land or fields; sowing fields
esiloshimpwiyu	holistic home care
kapana	fried meat
kraal	an enclosure inside the boundaries of a homestead complex, where animals are kept during the night (origin from Dutch settlers in South Africa)
kuku	grandparent, grandmother
mahangu	pearl millet – also *omahangu*

meme	adult female, mother, aunt
memekulu	elderly female, grandmother
nyateka	dirt
ohungi	traditional story telling
oilyavala	sorghum
okwaandako	the index finger
olupale	receiving area of the traditional homestead; the hearth area in the homestead reserved for stories to be told
omahangu	pearl millet
omalunga	palm trees
omanda	a millet storage basket
omapungu	maize
ombepo	literally wind, but used as a figure of speech for someone's mood or frame of mind
omumwayina	sister
omuyeni	strangers
onjuwo	guest
oshana	shallow depressions that are seasonally inundated
oshifukwa	groundnuts
oshikombo	goats
oshikuku	chicken coop
oshikwanyama	food storage system, large woven grain baskets raised on poles above the ground, specifically to store grain
oshikwiila	thick sweet bread, made on the open fire
oshini	place where *mahangu* (millet) is stamped

ovanhu uhevashi	people you do not know
ouve	fruit
oxuxa	chickens
tate	adult male, father, uncle
tatekulu	elderly male, grandfather
vakwa	children
vetkoek	similar to a bread dough but roundly shaped and deep fried
uundiningasho	traditional, locally brewed beer
yogoka	clean

Children of the Sun

Participants and their decorated pseudonyms

PROLOGUE

"We have a lot to tell"

Towards the end of April 2013, at the start of this research project and when I had the first meeting with the group of children who agreed to participate in the research, I noticed at the front of the class a small group of girls whispering.[1] They were as nervous as me and they started to talk amongst each other. "What are we going to talk about?" Another answered, "*Meme* wants to talk about being healthy or sick." They were poking each other in the ribs, making some of them almost fall from their tiny chairs. Another girl added, with a frown on her face, "Healthy or sick – why?" A girl in the same group shrugged her thin shoulders up and down and answered, "*Kandishiwo kuta okwa hala oku tseya shike kombinga yuundjolowele nuuwehame the otuna oshindjiokumu lombwela*." "I do not know what she wants to know about health and sickness … but we have a lot to tell." At that they all giggled, putting their hands in front of their mouths. I looked at them, feeling overwhelmed and still nervous myself, and tried calmly to gather myself. I asked, "You are very happy after such a long school day?" The bravest one in the group looked down, not making eye contact, and said, "We are happy to be here," and repeated, "And we have a lot to tell." This catchphrase remained in my thoughts throughout the eleven months of my fieldwork in the northern Namibian village and afterwards because, looking back, the children indeed had a lot to tell.

[1] I will use the terminology 'child' throughout my discussions which is a common term for primary school age children in Namibia between the ages of seven and fourteen, whereas the term 'youth' is more often applied to those aged fifteen and above. However, the term 'child' varies in definition and, according to the draft Child Care Protection Act in Namibia, a child is classified as being below the age of eighteen, in accordance with the United Nation's (1989) Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child (OAU [AU], 1990).

CHAPTER ONE

From dawn to dusk: a day in the life of a northern Namibian child

"Not too far – the clinic is around the corner"

After being in the village for three weeks, one afternoon I heard in the distance the voice of Boy-Boy[2] (who ended up being one of the young participants in the study), excitedly calling me to the gate of my homestead. He asked me to join him as he walked to the local clinic. He was persistent and refused to take no for an answer, assuring me that the distance to the local clinic was not too far and showing me how far by stretching out his small fingers. "*Meme*, it is just around the corner, do not worry," he said, as he gave me a broad smile.[3]

We took the dusty unmarked road, full of other commuters. Some were school children, who recognised me with a wave, while others, mostly children, went on with their daily business, accompanying elderly family members or occasionally passing us carrying a younger sibling with ease on their backs, just like Boy-Boy was carrying his two-year-old brother. A herd of cattle approached and a tiny boy ran around frantically, trying to avoid making more chaos. He made eye contact with us by jumping up and down, signalling for us to be patient. In the far distance, I saw children expertly balancing water on their heads in different coloured plastic containers, while others were simply rushing with empty containers to the nearby waterhole. As I waited for the animals to make their way past, a girl at a nearby homestead caught my eye, her hand filled with thin, dry twigs as she gently blew on the ashes to light a fire, while a few of her siblings offloaded piles of firewood. I heard girls singing and laughing while they pounded *mahangu* in a nearby hut.[4]

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[2] The children in this study all chose their own pseudonyms, in order to protect their identity. Pseudonyms are also used for the names of the village, the school and any people informally spoken to during the research.

[3] *Meme* is the vernacular use in the Oshiwambo language for 'aunt' or 'mother'. Oshiwambo is the language spoken by the Aaumbo, the biggest ethnic group residing in northern Namibia, one of the eight ethnic groups which still reside in Namibia. The name Aaumbo originated from the colonial name 'Ovamboland' and is historically attached to the South West Africa People's Organization (SWAPO), a liberation movement that originated in the northern part of Namibia and, following Namibia's independence in 1990, was elected to government and still remains in power. I use the neutral term Aaumbo to mean the Namibian people coming from the north in my discussions and, although I did not choose the young participants specifically from a certain ethnic group, all the children in this research came from Aaumbo descent.

[4] *Mahangu* are grains – pearl millet – from the local area that are pounded into powder and then cooked to make porridge.

As I watched Boy-Boy carrying his smaller sibling on his back, shifting the small boy from one position to another, it was almost as though he was carrying double his own weight. However, he still seemed to be comfortable enough to talk to me as we walked. I offered my help to carry his brother but he refused and just changed the position of the child on his back and continued the conversation. I was curious to know how he managed after being at school all day to still walk this long distance to the local clinic. Boy-Boy responded, "I am the eldest and in charge while my other brothers and sisters are attending schools in other areas." He added, "Well, it's my job and who else would do it because my grandparents are too old." He further explained that he did get tired but this was the least he could do because his grandparents had done much more for him and his siblings after his parents had died. I complimented him on the ideas he had shared the previous day in class while I was teaching[5] and let him know that I thought he did very well in school. Boy-Boy spoke shyly and softly and avoided making eye contact, as he told me that he hated to be out of school but occasionally he also had to take his grandparents to the hospital, which was even further away than the local clinic. He was however full of boasting and told me that he thought he was clever enough to easily catch up with his schoolwork because in various class tests he still beat the others who were more regularly at school. He noticed when I used a cloth to wipe off my sweat and laughed, telling me again that the local clinic was just around the corner. When we reached the tar-sealed road that signalled the end of the dusty road to the Village[6] we approached the clinic. At the local clinic it was abuzz with people – mainly children – some drank water from a leaking tap, trying to catch the water in their hands and use it as a cup, as others carried water to weary, elderly adults who sat at the front entrance of the crowded clinic grounds. Later I made careful calculations of the time we took to reach the local clinic and estimated that it was at least seven kilometres from the village where we resided.

[5] I had volunteered to teach at the local primary school for six weeks before the start of my study. A detailed discussion of my volunteer role will follow in Chapter Three.

[6] 'The Village' is the pseudonym given in this thesis to the particular village where the study took place.

“Heavy water cans? This is nothing …”

Another day, while I drove from the school to my homestead, I met ten-year-old Nangy, also a young participant in my study, carrying water along the road with a few of her younger siblings. I stopped and picked them up and offered to take them home. Nangy was very grateful because it was getting dark and they were still about four kilometres away from their homestead. As we loaded the water cans into my pick-up, I could hardly manage to lift them from the ground into my car because they contained more than 20 litres of water. I was eager to ask how they managed to carry the heavy water cans but Nangy simply smiled and told me, “Heavy water cans? No, this is nothing,” as she got into the pick-up and thanked me again for the kind gesture. I realised that Nangy had not been at school that day and had also not attended our afternoon research session and started a conversation by asking her if she would come to school the next day. She explained to me that she had needed to take her siblings to the local clinic because they had diarrhoea but she was happy that the clinic had some medication for them because it meant they would get better soon and then she could go back to school. She asked me to stop as we approached their homestead. As I began to stop the car, she was already busy instructing her siblings to get out of the pick-up and gather some wood so that she could start the evening meal. I told Nangy that I could drop her and come back to collect the boys with the firewood. She was grateful and told me her grandmother was not able to move easily anymore and she was worried that she might be hungry as there had not been anybody to look after her during the day. Nangy talked passionately about her grandmother as the only mother she had ever known and how it was her responsibility to look after her “mother-grandmother.” With a bright smile and a sparkle in her eyes she said, “That is what my children or my grandchildren will do when I get old.” When I came back with the two boys to offload the firewood, everyone else was gathered together and it seemed to me that Nangy was too busy even to say goodbye as she was busy in the cooking area of the homestead trying to light a fire. However, as I drove away from their homestead I saw in my rear-view mirror Nangy running and waving goodbye in the distance.

Children’s worlds

When I wrote these events in my field diary in April 2013, while living in that small village in northern Namibia and exploring nine to twelve-year-old children’s understandings of health

and illness, I realised that these children were not simply performing their daily chores. Rather, in their daily lives they were constantly adjusting to their changing social environment, striving to become agentive social actors. As David Lancy (2008) argues, how children are socialised, their role in their community, and the way in which community and family are organized around children differs cross-culturally. In this thesis, I focus my analysis on northern Namibian village children's experience in their day-to-day lives: how they cope, manage and survive through their experiences of health and illness. Throughout fieldwork I was struck by how these children navigated ways to develop influence in making choices in their lives, taking responsibility and actively caring for others, and working out their shifting degrees of voice and visibility. They integrated local knowledge within health challenges, gathered information and resources as they needed them, coped with the rise of new kinship forms and changing roles in the local economy, and engaged with modes of reciprocity in order to survive, thrive and hope for a better future. I therefore locate this study within of the anthropology of childhood, which seeks to move beyond notions of children being passive and helpless (Skovdal et al., 2009; James, Jenks & Prout, 1998). Through ethnographic analysis, I will show how the children in this study become pivotal agents within a social environment where health and illness have profoundly changed social life in Namibia (Edwards-Jauch, 2009; Kalomo, 2015).

As early as 2010, 30 per cent of children in Namibia were living without either of their biological parents, and the elderly had become central to local parenting responsibilities and strategies (Reijer, 2013; Kalomo, 2015). My thesis will show how parental responsibilities are transferred on to children and, as implied in the stories above, how the roles of grandparents have correspondingly changed. Numerous studies in sub-Saharan Africa and Namibia have focused on the needs of elderly people and orphaned children (Dayton & Ainsworth, 2004; Ice et al., 2010; de Klerk, 2011; Kalomo, 2015), but few studies have focused on children and their role in households as agents, particularly as their grandparents and other kin members age and need new forms of care, and as the health crisis of HIV in Namibia continues to affect families. Children's active participation within health systems as mediators and interpreters demonstrates the multi-layered agency by which children interpret and address the various health challenges within communities. The children's contribution within their households and local economies also helps to sustain

their own and their family's wellbeing, treatment of disease, and strategies to deal with poverty.

Engaging with theories of care, agency, biopower, citizenship and responsibility, I argue that children develop different, multi-layered agencies. These help them to cope with the difficulties brought about through the challenges of disease and illness by actively becoming involved in their households, medical systems and broader communities. This study also identifies how, despite the Namibian government's control over the school curriculum, and their ultimate goal of crafting better citizens and realising national health goals, children creatively apply cultural ideas of wellbeing, health and the body at school and at home when health crises prevail. Additionally, this thesis considers the consequences of a health disaster – HIV/AIDS – when kinship systems and national expectations of childhood are severely challenged. Children's roles become vital in local clinics, schools and hospitals, where they become mediators and interpreters, and at home, where they constantly have to work around stigma and secrecy and where very real and practical limitations exist.

Core focus

Through fieldwork in which children were the focal point, I came to realise that the children's catchphrase – "We have a lot to tell" – revealed the children's multi-layered agency. One the one hand, it represented their ability to make intentional, reflective choices in their life, and their enactments of their will, freedom and empowerment (Ortner, 2006). On the other hand, the children in the study also expressed agency through their responsibility for others, in performing actions of daily care and by embodying a complex ethics of care (Mol, 2008; Held, 2006) and responsibility (Laidlaw, 2000). Agency was furthermore expressed in how the children enacted voice and visibility, and worked with in and around situations of secrecy, silence and stigma. One of the major obstacles in fighting the HIV/AIDS epidemic in Namibia is stigma and silence (Angula & Ncama, 2016; Angula, Ncama & Frohlich, 2015; Thomas, 2007). Children learnt to manoeuvre within the confines of these challenges in which their voices were constrained. I therefore do not cast agency simply as the ability to enact one's will, but the way in which one learns to act within a social environment and its constraints, how one learns to act for oneself and for others, and how children make choices when the options are limited.

It is normally assumed that children need to be provided for, but as will be seen in this study, the children carefully demonstrated tactical ways and strategies of survival, making a living to provide for themselves and others through reciprocity and exchange. The children showed that in the wake of limited information from the school curriculum and constrained home-based resources, they devised ways to work towards the health of the family. They relied upon careful daily observations within their households and integrated local knowledge into places where it was practically needed, such as at school, to protect themselves from major health threats. I contribute to the anthropology of childhood by arguing that even within social worlds in which resources are constrained, health challenges are acute, and even where children traditionally lack social status, and children can still be seen as active agents. My work is thus in line with Lancy's (2008), who observed similar innovative responses from children to changing social structures. He argued that such changes would and should serve as a "catalyst" for those working with children in Africa, and specifically in southern Africa and Namibia, challenging views of children that cast them as passive dependents or as property, with incomplete modes of personhood, and confronting practices that make children's contributions invisible.

Namibia and the "Children of the Sun"

The children in this study named their group the "Children of the Sun". The name was agreed upon after one group member pointed to the flag, faded from the harsh weather conditions, flying on a flagpole outside the classroom window. The 'sun' is one of the symbols represented on the Namibian national flag. This symbol embodies both the vast desert climate of Namibia and its antecedents as a country with a fierce political history of various colonial experiences, from the Germans in the 1880s to the South Africans in 1948.[7] Namibia borders South Africa in the south, Botswana in the east and Angola and Zambezi in the north (Figure 1). The location of the study area, in the north of Namibia, is shaded with diagonal lines in Figure 1.

[7] Namibia is located in southern Africa, south of the equator, and consists of five geographical areas – the Namib Desert (one of the oldest deserts in the world), the Bushveld, the Kalahari Desert, the Great Escarpment, and the Central Plateau.

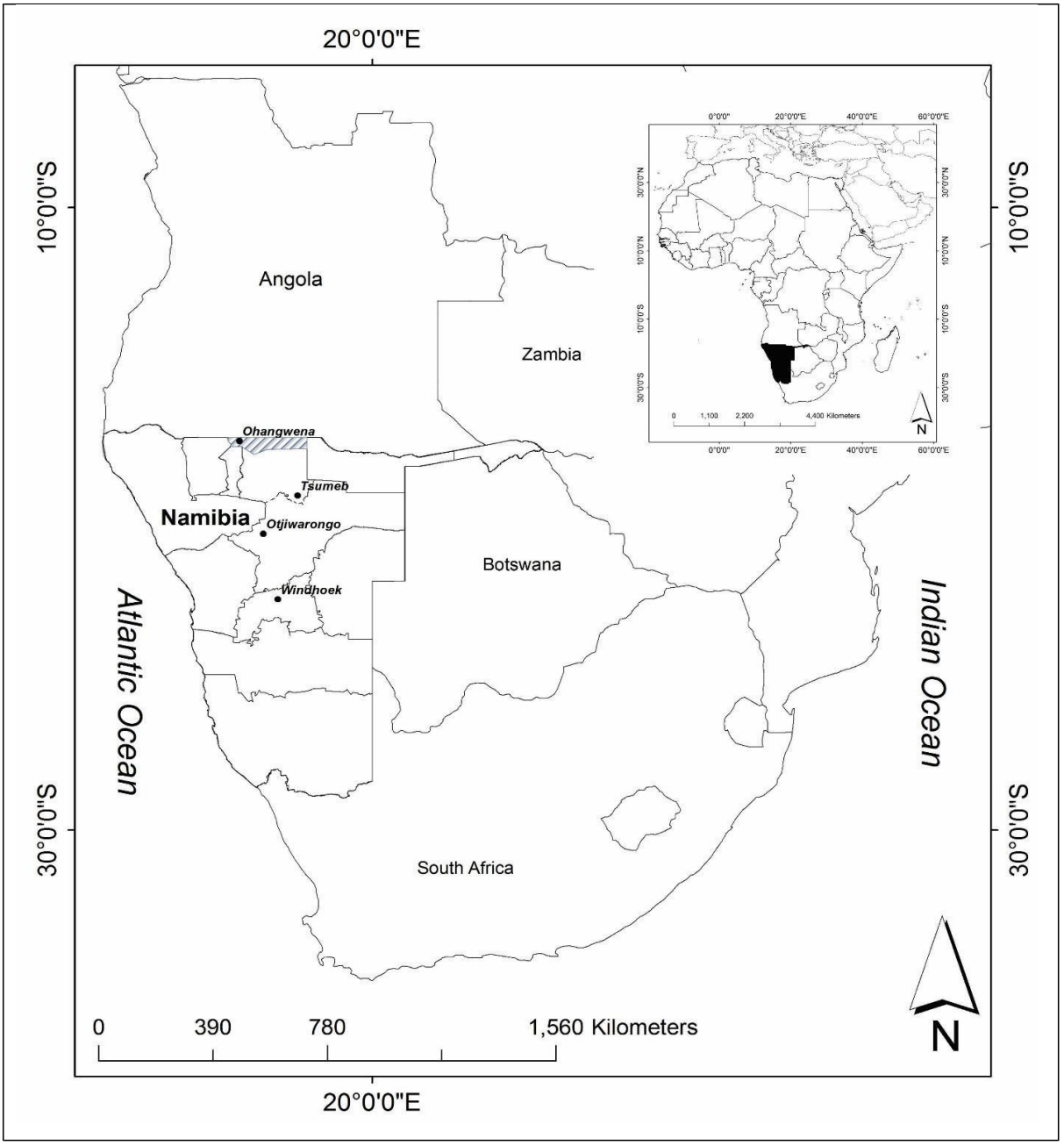

Figure 1: The location of Namibia and the study area

Namibia gained independence in 1990.[8] This juncture, however, marked the onset of yet another battle, this time in terms of health, particularly in relation to an increasing HIV/AIDS

[8] The country is economically stable, with a growth rate of the domestic economy which rose from 4.7 per cent in 2013 to 5.0 per cent towards the end of 2014 and a gross national income per capita of $9,590 (Bank of Namibia, 2013). Namibia's economy revolves around tourism, with its unique desert and coastal sceneries and abundance of wildlife, and mining, which includes mining for uranium (Namibia is the fifth biggest exporter in the world), silver, gold, diamonds and base metals. The mining sector has recently declined due to a fall in the price of diamonds across the globe (National Planning Commission [NPC], 2013).

epidemic. The first case of HIV/AIDS was reported in 1986. In 2005, the then president of the country, Hifikepunye Pohamba, said in his speech at the launch of a HIV/AIDS booklet in the capital city Windhoek, "It is indeed a sad reality that because of the HIV/AIDS pandemic, our children are now compelled to face and deal with issues that are, in fact beyond their scope'' (Hamutenya, 2005). The political use of the public health concept 'pandemic', which in essence means an epidemic happening over a huge stretch of area, where a high number of people are affected, represented a moment of public reckoning for the country and the recognition that in Namibia children were becoming increasingly affected.[9] Namibia has a very small population of 2,113,077 million, with a growth rate of 1.5 per cent over the last ten years (Ministry of Health & Social Services [MoHSS] & ICF International, 2014, 2). Thirty-seven per cent of the country's population is under fifteen, while the zero to five-year age group accounts for 13.5 per cent of the population (Directorate of Primary Healthcare [DPH], 2014, 14).[10] The country has one of the highest HIV prevalence rates in the Sub-Saharan African region, with a peak prevalence rate of 22 per cent in 2002 and a decline to 18.8 per cent in 2010 (MoHSS, 2012). At the time when this study took place the measured HIV prevalence rate was 14 per cent in the general population (MoHSS & ICF International, 2014).

Namibia is classified as a lower middle income country, however, as Levine and Roberts (2013) observe, while Namibia has an average per capita GDP of US$2,100 (four times the average for sub-Saharan Africa), there are "large pockets of poverty" and therefore average income as a whole is misleading as a measure of welfare for the country, which hugely struggles to fill the gap between the rich and the poor. Levine and Roberts (2013) further note that there is a severe level of inequality in income distribution, quality of life and standard of living. According to the *Namibia Child Survival Strategy, 2014-2018* (Directorate of Primary Healthcare [DPH], 2014), 28.7 per cent of adults and 34 per cent of children live below the Namibian national poverty line.

Namibia is challenged with one of the biggest inequalities in wealth in the world and the gap between the rich and the poor is extremely visible in the rural areas of the country and even in the outskirts of urban areas, particularly in the capital city Windhoek, where huge urbanisation has taken place and people are continuously looking for employment and a better standard of living (NPC, 2013, 14).

[9] The two terms 'infected' and 'affected' have specific meanings in medical anthropology in relation to HIV/AIDS, which will be used throughout my discussion: 'infected' is used to describe people who are themselves HIV positive and the term 'affected' refers to the children participating in my research who are living with a person who is HIV positive or are otherwise affected by the HIV status of another person (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2012).

[10] In 2005, when President Pohamba made these comments, it was reported by the World Health Organisation (2004) in their 2004 annual report that that Namibia had a HIV/AIDS prevalence rate of 20 per cent and more than 210,000 adults and children were HIV/AIDS positive. Namibia was also classified as one of the five countries in the world most severely affected with HIV/AIDS. In 2003 alone, 57,000 children lost both their parents.

Namibia's social geography poses particular challenges in addressing these health concerns. The Namibian population measures the second lowest density in the world, with only 2.5 inhabitants per square meter, which creates challenges in terms of organisation, planning and logistics in all AIDS responses, and the distribution of other forms of medical care. For children in remote rural areas, such as the young participants in this research, these challenges have become part of the daily life of their childhood, as they have filled crucial care roles, become lay medical experts, and accompanied sickly siblings, grandparents and other family members to clinics and hospitals, a topic I explore further in Chapter Seven.

Children and HIV/AIDS in Namibia

The *Namibia Child Survival Strategy, 2014-2018* (DPH, 2014, 39) states that more than 14,000 children below the age of fifteen are HIV positive, mainly through mother-to-child transmission. Eighty-eight per cent of these children are on Antiretroviral (ARV) medicines at the respective Antiretroviral Treatment Centres (ART) at local hospitals and clinics. The same report suggests that Namibia has made progress in tackling and reducing the infant mortality rate which has dropped from 69 per 1000 live births in 2006 to 55 per 1000 live births in 2013, due to vigorous investments made in the health sector by setting up more local clinics, increases in ARV medicine distribution and awareness campaigns throughout the entire country and combating other communicable diseases, like malaria and HIV/AIDS, which are major players in aggravating the tuberculosis (TB) situation (DPH, 2014).

Addressing the health needs of children is intrinsically linked to attending to wider issues of poverty. 275,000 of Namibia's children live in poverty. While this is a substantial decrease from the estimate of 345,000 in the 2003/2004 Namibia Household Income & Expenditure Survey, it indicates that 34 per cent of children are poor versus 29 per cent of the broader Namibian population (Namibia Statistics Agency [NSA], 2012). This illness burden that disproportionately falls on children is visible in low birth weight, child mortality, high levels of stunted growth, high levels of underweight, and poor nutrition.

These realities were tangibly present in my field site. Most of the children I came across were physically small for their ages, had skin rashes, eye illnesses and seemed to be under-

nourished. Mostly, when I accompanied children in my research with their siblings to the local clinic, those children had diarrhoea and severe skin rashes which were explained by the local nurse as aggravated by the low water levels in the *oshana* (shallow depressions that are seasonally inundated),[11] due to the ongoing drought, and locals who failed to boil water or use the water purification sachets distributed at the clinic. The children who participated in my research indicated that they had knee and neck pains and headaches, which the local doctor and nurses explained to me were the result of the constant carrying of heavy items, such as water cans and wood, on their heads. Changes in kinship systems (discussed in Chapter Seven), particularly new kin strategies required to deal with the death and illnesses of adult relatives from AIDS, created new care challenges for children (discussed in Chapter Four). The daily hardships felt by the children in this study generated new strategies for survival in which they sought to build their lives, make the most of opportunities, and dream about the future.

Two-thirds of the Namibian population live in rural areas, mostly in the four northern regions of the country, and less than one-tenth live in the southern part of the country (MoHSS & ICF International, 2014). All areas have a communal form of land ownership. Within rural villages, food security problems are aggravated by global warming and a lack of economic and social infrastructure. For example, tar-sealed roads lead only to villages and within villages there are only dirt walking tracks made by the villagers, making driving inside villages during the rainy season very difficult. The village where I based my research had no electricity and almost no running water. Only one of the 26 children in the study had a flush toilet at their house.

Namibia's commitment toward the child after independence

In 2014, the World Health Organisation (WHO, 2014) in the report, *Health for the world's adolescents*, urged all societies to make the health and wellbeing of children a primary goal. Accordingly, African nations (including Namibia) strove to re-draft their current national laws to align with the Convention on the Rights of the Child (United Nations General Assembly [UN], 1989) and the African Charter on the Rights and Welfare of the Child (Organisation of African Unity [OAU] / African Union [AU], 1990) The Ministry of Gender

[11] *Oshana* (singular and plural) in the Oshiwambo language describes drainage channels which interconnect with others in the Cuvelai Basin system (Mendelsohn, el Obeid & Roberts, 2000).

Equality and Child Welfare (MGECW) in Namibia was established in 2000 to look into the specific needs of children and woman and to carry out the child welfare role previously under the purview of the Ministry of Health and Social Services (MoHSS, 2008, 1). The MGECW has three main programmes: namely Child Welfare, Gender Equality and Community and Integrated Early Childhood Development. The Minister, in the preface of the *Children and Adolescents in Namibia* report (National Planning Commission [NPC], 2010, x), stated the following:

> Children and adolescents are at the heart of Namibian society, the forefront of national development, and the leaders of the future. When we focus on economic growth, poverty reduction, service provision or social inclusion, we need to ensure that the benefits reach the nation's children and young people, as they are integral to reaching our shared objectives, and their empowerment is essential for success in achieving our long term goals.

Her remarks reflect Namibia's further commitment to various Acts of Parliament relating to youth and welfare, which include the *Combating of Rape Act*, *No. 8 of 2000*, the *Combating of Domestic Violence Act, 2003*, the *Criminal Procedure Act, 2004*, the *Children's Status Act, No. 6 of 2006* and the National Policy on Orphans and Vulnerable Children of 2006. During the past decade, the government has invested and allocated significant resources to children in terms of education and health (Kasanda, Keyter & Zealand, 2012). The Namibian government immediately accepted the 1989 UN Convention on the Rights of the Child directly after independence in 1990 and pledged to protect all children in the country in the various aspects of their growing lives. The Namibian Parliament therefore committed themselves to a report submitted to the United Nations Committee on the Rights of the Child, outlining Namibia's position and the major obstacles, gaps and challenges that existed after independence. The first situation analysis of orphan children in Namibia (NPC, 2010) study was embarked upon in 1992 and released in 1995, covering various aspects and challenges on the ground with regards to children in the entire country. Furthermore, Namibia committed itself to the UN Millennium Declaration in 2000 and set out broad strategies aimed at reducing inequality to meet the Millennium Development Goals of 2015.

Namibia is also one of the few developing countries which has established a Children's Parliament, which was opened in May 2007, with a mission statement asserting, "The Mission of the Namibian Children's Parliament is to create a developing society with high sense of responsibility, of which children and the youth are part, with adults as partners" (Children's Parliament, n.d.). Parliamentarians are chosen from the thirteen regions in Namibia and there are 54 members in total. The main purpose of the Parliament is to make recommendations to the Namibian Government and all relevant departments working to ensure the welfare and rights of children and therefore trying to expedite the implementation of relevant policies to further improve the lives of children in Namibia.[12] All of these examples and initiatives demonstrate that politically, children and their health and wellbeing are an important figure through which the government attempts to demonstrate its 'progress', modernization, and social legitimacy to govern.

[12]The ages of the children in the Children's Parliament range from fifteen to seventeen years old and each child is attached to a secondary school and acts to represent the needs of all the other age groups at that school. In May 2013, the Children's Parliament had its fourth session and during this session tabled 98 motions for debates. The significance of this session was that it made recommendations to the draft Child Care and Protection Bill, which was still extant under the old South African law as it had been since 1960. The draft Bill consists of eighteen chapters and the sections in urgent need of change are those dealing with child-headed households, vulnerable children, children with disabilities and international adoption. The Bill was due to be tabled and approved in 2015 but is still outstanding. The draft Child Care & Protection Bill of Namibia is currently under review and is envisaged to replace the *Children's Act* of 1933, inherited directly from the South African colonial system and widely regarded as an outdated piece of legislation, unfit for purpose and obsolete in terms of the current situation of children in Namibia. Following consultation with relevant stakeholders and various reviews, the Bill under consideration by Parliament was later divided into two sections – the Children's Status Bill and the Child Care Protection Bill – as the result of a workshop held in 1994. After its establishment, the Ministry of Woman and Child Welfare in Namibia (now the Ministry of Gender Equality and Child Welfare), was assigned to oversee the draft Bill discussions with stakeholders at further consultative workshops held in 2001 and 2002. Recommendations from these workshops were then further discussed by an appointed Ministerial Committee, specifically representing the Ministry of Home Affairs, the Ministry of Health and Social Services, the Legal Assistance Centre and the Office of the Attorney General. All recommendations made by these particular Ministries were forwarded to the Ministry of Justice, which handed their final recommendations to the Namibian Parliament in 2003. The approval process continued with input from both the National Assembly and the National Council (the two Parliamentary Houses in Namibia), with a shorter version of the Bill being approved for consideration in 2006. The current draft Bill was based on the updated South African *Children's Act* of 2005, an amendment of the previous *Children's Act* of 1933. Due to many changes in the Ministry of Gender Equality and Child Welfare and the appointment of new personnel, several years have gone by since the start of the review of the draft Child Care & Protection Bill in Namibia. Renewed discussions and consultation with the Legal Assistance Centre in Namibia and UNICEF took place last year in 2015, to include national and international needs of children identified since the start of discussions in 1994 and to allow the inclusion of some of these critical issues before the Bills are finally approved.

Current health issues facing the children of Namibia

These organisations and strategies identify a number of challenges facing Namibian children, including HIV/AIDS; poverty; youth unemployment; alcohol and drug abuse; early school dropout rates; migration from rural to urban areas; gender-based violence, particularly against women and children; early sexual engagement, leading to teenage pregnancies; and foetal alcohol syndrome amongst children born from alcoholic mothers (MoHSS & ICF International, 2014). These entrenched factors hamper the wellbeing of children and youth in Namibia severely, and are linked with major social issues such poverty, fuelling or fuelled by health issues such as HIV/AIDS, malaria, alcohol and drug abuse.

Current governmental health programs focus strongly on the zero to five age group and their mothers through policy formulation, strategic plans and several guidelines put in place by the Ministry of Health and Social Services covering the principal Primary Health Care Policy. These are due in part to the international pressure to meet acceptable targets for child mortality and morbidity through the Vision 2030 goals for developing countries, and other national frameworks.[13] These include a raft of strategies aimed at the major health challenges Namibia faces, for example:

- the National Policy on Reproductive Health;
- the National Policy on HIV/AIDS;
- the National Malaria Policy;
- the Malaria Strategic Plan;
- the National Guidelines on Infant and Young Child Feeding;
- the Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality;
- the Feeding Guideline on Nutrition Management for People Living with HIV/AIDS;
- the National Guidelines for Adolescent Friendly Health Services.

[13] For example, the five-year National Development Plan (MGECW, 2010) is the country's more refined measure, and has been put in place through the *Namibia Child Survival Strategy, 2014-2018* (DPH, 2014) which, in line with the National Development Plan-4 (NPC, 2012) and Health Sector Strategic Plan (2014-2018), guide the Ministry of Health and Social Services in how resources must be allocated to ensure child survival through the following policies. The 1998 National Health Policy Framework (NHPF-1) was reviewed in 2008 and the updated policy framework (NHPF-2) was made available in 2010 (MoHSS, 2010).

While the Namibian Constitution states that a child is defined as someone under the age of eighteen, most programs and policies in place are geared towards mothers, as the child-bearers and as caregivers of children, and place huge emphasis on guidelines and policies for mothers and children in the zero to five age group. Attention is also focused on the fifteen years and above age group, in terms of concerns of reproduction and sexuality and the fifteen to seventeen-year-old age group is catered for through the National Guidelines for Adolescent-Friendly Health Services health programs.

There is, therefore, little support for the six to fourteen-year-old age group, in terms of specific health policies and support. Children aged six to fourteen still receive vaccinations, but their access to paediatricians is limited because of prioritisation of the zero to five age group and limitations in the availability of specialised doctors, in urban as well as rural areas. Furthermore, this specific age group accesses doctors with the wider general public, with the exception of those children infected with HIV/AIDS who see doctors through the ARV treatment centres. The age group of nine to twelve years old, represented by the children in this research, are the only age group left living in the village to support their families, as older children have either left the village to attend junior or secondary schooling or in search of better job opportunities. Children attending junior or secondary schools tend to stay in school hostels or move in with family members in urban areas of Namibia for better schooling opportunities. This situation leaves the elderly behind with younger children.

The Ohangwena Region and the anthropological field

I conducted my research in the Ohangwena Region of Namibia. The Ohangwena Region is located in the northern part of the country, with Angola to the north, and is bounded by the Oshana Region of Namibia to the west, the Kavango Region to the east and the Oshikoto Region to the south. It forms part of the thirteen administrative regions of Namibia and has eleven constituencies, with Eenhana as its capital city. The region has a population of 245,446, comprising 12.5 per cent of Namibia's total population (NSA, 2013, 16). According to the Ministry of Health and Social Services of Namibia, the Ohangwena Region is one of the most “challenged regions” in terms of high mortality rate of more than 22 per cent, as compared to fourteen per cent in the rest of the country. More than a quarter of all the

households in the region have experienced an HIV death in the family and there is a high number of orphans[14] and vulnerable children (MoHSS, 2012). The region also has a higher household size of 5.6 people, as compared to the country-wide average of 4.6, and 67 per cent of the households are headed by woman (NSA, 2013, 16). The size of the families I visited during my home visits in 2013-2014 were slightly higher, with more than 8.2 people per household, and all of the households were headed by females. The females who headed the households were mostly over the age of sixty; however, two of the women were in their mid-forties and neither was married. The elderly women were mainly living on state pensions[15] as their main source of income, which sustained the entire household. In discussions with my young participants, only six out of the 26 children received additional smaller amounts of money from family members working in the cities to help with extra food and medications.

In the past, the wealth of an Aaumbo family was measured in relation to the family's size (Mendelsohn et al., 2000). Economic and social transformations in the Oshiwambo region, and in Namibia more generally, mean that although the number of people in a family has not decreased the potential to accumulate wealth has shrunk, due in large part to urbanisation, the cost of education and healthcare, as well as the monetisation and marketization of the economy (Mufune, 2011). The health situation in terms of HIV/AIDS has also had a severe impact on the wealth of the Aaumbo, with the most productive members of a family dying, leaving families made up of the elderly and the young. Driving through the village, most homesteads were abandoned, and drought and the previous year's flooding left previously ploughed fields in decay. The Ohangwena Region mainly operates on subsistence farming, growing small scale *omahangu* [pearl millet] fields and

[14] The 2011 *Population and Housing Census Regional Profile* (NSA, 2013) for the Ohangwena Region reported that 16.5 per cent of the people in the region had lost one parent, while 3.5 per cent had lost both parents.

[15] The state pension was around NZ$60 per month at the time my research took place and increased to NZ$160 after the 2014 general election. Namibia is one of the few countries in Africa which provide social security benefits in the form of old age pensions to their citizens from the age of sixty and above. The local Broadcasting Corporation (NBC) announced in April 2016 that number of people provided social grants by the Namibian government had increased from 177,594 to 194,532. These numbers included a total number of 159,315 grants given to senior citizens, while the rest are allocated to orphans, vulnerable children and people with disabilities.

breeding livestock, such as goats [*eekombo* or *oshikombo*], chickens [*oxuxa*], donkeys, cows and pigs, which are mainly for household use and consumed during ceremonial occasions.[16]

The Village

"*Oho shi ithana omukunda,ngame ohamdi shi ithana egumbo.*"

"You call it 'village', we call it 'home'."

Figure 2: Grandmother in the millet harvesting fields

"Home" was the name used for the village[17] by one of the passengers who gave me an introductory tour on the very first day I entered the road to the village. The village had 30 households and about 350 people lived there, with the extremes from very young to very old, but few in between.[18] The oldest person I met was 101 and still worked in the millet fields. Elderly women were matched by a high number of young children. Fourteen to

[16] A cow is usually slaughtered during funeral and wedding celebrations and chickens are mainly cooked as welcome gifts for visitors, as was done for me on the first night I arrived to stay with my homestay family.

[17] In the Aaumbo tradition a village is an area where people reside who are not necessarily related to each other. The village had communal places where the locals met like the *cuca* shop (a small local store where basic food items and also locally brewed beer - *uundiningasho* - could be obtained). Most villages had a church and a local graveyard.

[18] This is in line with the *Population & Housing Census Regional Profile* (NSA, 2013) which indicated that that 29.3 per cent of children staying with the heads of families were grandchildren, while only five per cent of the households in the Ohangwena region were comprised of husband and wife.

eighteen-year-old children would leave to attend high school and, as the schools were mostly far away from the village, the children resided there in boarding hostels. Those who did not attend high school went to the neighbouring towns or the capital city in search of work opportunities.

On the first day I entered the village, as I turned off from the clearly marked, tar-sealed main road, I passed by the only clinic in the village, which was used by all the village residents. The last stretch of that tar-sealed road connects after a few kilometres with the unmarked village road. As I turned on to it, I was immediately forced to roll up my windows to avoid the dust made by another vehicle in front of me and to try and avoid some pigs, goats, dogs, and cows standing half in the road and eating from a large garbage container. I was not alone taking the sandy and bumpy road, although at first it seemed to lead nowhere. With my car sinking into the sand, my driving skills were heavily tested trying to get used to the unsealed, potholed surface and avoiding the locals and animals crossing the road.

My speed dropped from 120 kilometres an hour to almost twenty and I felt as though I could easily walk beside my own car. I was greeted by other road-users within metres of the village – a few boys herding their cows, followed by chickens, dogs, donkeys and goats, all frantically crossing the narrow, potholed road. The boys laughed at my facial expression, as I tried to avoid them and they respectfully led their herd off the road into the bushes.

As I entered the village, with its landscape of flat surfaces, unevenly spread bushes and scattered palm trees in the distance, and carefully tried to drive over potholes as slowly as possible, I was greeted by the friendly locals, almost all holding cell phones attached to one ear and waving with the other hand. A loud voice attracted my attention and I saw a *meme* walking along the road, shouting through my closed window, “You look lost.” I rolled down my window and told her I was on my way to a family in the village. She replied, “You call this a village”, and before I could answer, she shouted back, “We call it home.” The slow pace of my driving made it possible for her to walk alongside my car. She took the opportunity to get into my car and take a short ride for the few remaining kilometres that she would have to have walked. As she got into my car, she uneasily ignored the noise reminding her to put

on her seatbelt and proudly said, “Although my home does not have any electricity, running water or toilets, I will never leave it because it is my home and that of so many others staying around me.” I laughed and stopped my car to help her to put on the seatbelt and we went further into the village. Having her with me actually relaxed me, by distracting my attention from the ordinary buzz of animals, people and taxis trying to cut in ahead of me.

Children running, carrying huge white, blue, green and black plastic 20-litre containers, caught my eye, as they eagerly headed to the *oshana*. I was amazed by the swift movement of those full water cans and how easily the small children managed the balancing act of carrying those containers. It seemed as though they were carrying light empty vessels. The finesse of the children going down into the *oshana*, collecting the water and the balancing act of lifting it back onto their heads was amazing. Their legs seemed not to wobble in any way under the pressure of the heavy container as they steadily made their way back up onto the road. It seemed that only I noticed that the container was larger than the carrier and that they carried it with such ease, talking and laughing on their way home. Various other modes of innovation to utilised carry the water cans seemed to exist in the form of wheelbarrows, donkeys, and a few cars, but mostly it seemed the young children carried those water cans.

It seemed a lot of fun at the waterhole, with some children swimming, others doing washing and animals drinking. The water level was low inside the *oshana,* which is normal for the dry period of the year between April and November when there is no rainfall. Everybody collecting the water eventually joined the road, which made the traffic even slower. I suddenly saw the primary school, where 22 of the school children who participated in the research attended school, and next the graveyard, filled with modern tombstones and almost full to capacity. I was told that the local church was much further on, near the boundary of another village.

As I drove further into the village, I saw the start of homestead complexes,[19] not more than 500 metres from each other, clearly marked by tightly woven, thick, wooden stick fences,

[19] In the Ohangwena Region, a homestead is several houses (huts), differing in size, built in a traditional way (mostly circular) with local materials (grass, mud, dung, reeds and sticks) and known as the *egumbo*. The

forming a circular enclosure around approximately five to six houses. These houses had a distinctive appearance because the rooves were covered with thin sticks woven to a point in the centre.

Figure 3: *Egumbo* in the village

Some of the rooves needed replacement because of deterioration under the harsh, sunny weather. Some homesteads appeared to only contain traditional houses, while others had adopted modern western architecture, building with bricks and zinc. *Kraal* [20] occupied a space within the boundaries of the fences. *Mahangu* fields were lying barren because *mahangu* harvesting season had come to an end. The harsh drought situation in the country at the time of my fieldwork had surely taken its toll and the fields looked rather empty and dry, with cracked surfaces.

I was told by my *meme*, my newly found tour guide, that the modern houses amongst the traditional structures mainly belonged to the educated, older children, who occasionally returned from the city, and no longer wanted to live in the 'stick' houses any more. She

homestead is surrounded by pearl millet (*mahangu*) fields and all of the people in the homestead typically belong to one extended family. These huts or houses mostly providing sleeping areas to families, while some are used to pound *mahangu* or to store food. Most of the homesteads also had an *oshikwanyama* structure, large woven grain baskets raised above the ground, specifically store grain. No cooking takes place in the houses and instead food is mostly cooked within a demarcated area outside where water is stored and food is prepared.

[20] In the Aaumbo tradition a *kraal* is an enclosure within the boundaries of the homestead, where animals are kept during the night time and which serves as a shelter against theft or bad weather conditions. It is a word that originated from Dutch settlers who came to South Africa in the 1960s. Inside the homestead fences there is also uncultivated land called *ekove*, which is an area where livestock graze.

looked proud and happy, as she added, “I think it gives a good flavour to the village.” Our journey together came to an end when some children ran towards the car, the boys admiring my tyres and jumping onto the car to look in, calling out greetings. *Meme* indicated to me she needed to go but, before she became one of the throng of road users again, she pointed in the direction of her home and invited me to come and see her house. Our journey ended about 800 metres from where I needed to go and I had been converted, looking forward not just to living in a village but in this ‘home’, which became my haven for the eleven months I stayed in the field.

Thesis outline

My main purpose in this ethnographic study was to understand the daily lives of children, growing up and facing various challenges in their lives relating to health and illness. I wanted to understand such individual lives in relation to their wider contexts, of lives lived within families, friendship groups, neighbourhoods, hospitals and clinics. I wanted to find out how children came to know about health and sickness through their schooling and non-schooling environments, how they came to make sense and carve out health and illness solutions for themselves and the others they cared for.

In the wake of the numerous health challenges in Southern Africa, especially those related to HIV and other public health concerns, it becomes extremely important to investigate childhood anthropologically; to outline children’s positions as advocates, child mediators and carers. This thesis is the story of how the young participants survive these challenges and overcome adversity in their society. These children, particularly the 26 participants who formed part of my study, still have hopes and dreams for bigger and brighter futures, and they have developed their own interventions and strategies to cope. The children who formed part of this study are in a remarkable position: as children who must negotiate an adult-centred society every day, all the while taking control and working around pressing issues of illness, death and health. Instead of identifying adults and institutional structures - be it school, clinics, hospitals, neighbours or caregivers - as constraints, the children utilised these structures to conceptualise ideas and choices about health and illness and eventually the care they provided, to make their own daily lives and that of others easier and more liveable.

Chapter Two describes the motivation that led me to do a study where children became the main participants. The chapter outlines the methods and ethical dilemmas of working in the field and the different participatory methods used during my fieldwork. The different participatory methods used did not just enhance the anthropological approach but also enabled me to see how children's health and illness experiences are reflected upon, making them resources in the children's daily lives. Chapter Three outlines the core theoretical ideas utilised and advanced in this thesis, with a focus on how agency has been conceived anthropologically.

Chapter Four contrasts "health" as a subject in the school curriculum with the health that these children in a small village town in northern Namibia experience on the school premises and in their daily lives in the village, and how these experiences inform them in becoming biomedical citizens. Health as an object in the school curriculum reflected the gaps that exist between the school health curriculums and their daily realities, pragmatic strategies, cultural norms and traditions. I trace the daily experiences of the children within local medical institutions, with the major challenges of the shortage of trained professional medical staff and the distances and financial constrains to reach the local clinic and regional hospital facilities. The relationships forged between the local nurses, foreign doctors and the children's challenges, frustrations and their own solutions demonstrate their relationships within these different spaces. The children's roles in the local clinics and hospitals lead to their becoming child mediators, as an extension of their daily multi-layered agency roles as of carers for their family members in the home environment, and highlight the children's power, in terms of their ability to function in an asymmetrical environment.

Chapter Five examines children's own perceptions of their bodies, illness aetiologies, and the challenges they face in trying to stay well. As an ethnographically focused and experience-near discussion, this chapter seeks to centre the children's bodily life through their own words and visual representations. I deal in Chapter Six with children's experiences of illness, specifically with the devastating ongoing HIV/AIDS crisis in Namibia and the significant issues of secrecy and stigma that they face. In contrast to the secrecy of adults, children in this study tend to think and argue differently. The children regarded the visual

participatory ethnographic material produced through photovoice as an adventure and one of the most valued learning experiences gained from all my participatory methods. However, it was the photos in which they hinted at such familial issues that meant the most to them, and which were sometimes deeply painful topics.

Chapter Seven rethinks the ethics of care in the midst of health and illness challenges in northern Namibia, and further discusses the role of children in taking care of others instead of the westernised notion of children being taken care of by parents. Marilyn Strathern's (1987) argument on the "partible" person. Whereby these children in the study, through health and illness concerns that arise in their daily circumstances, create understandings of exchange through the idea of the partible person. This chapter emphasises further, through the understanding of the partible person, the contrast that exists in the notion of the west, where children is seen as innocent and a time of being playful, rather than taking up responsibility and being burdened with care. The children in the study see care as giving back, reciprocating what they felt was given by grandparents and guardians taking them in after the loss of parents, through giving of themselves in terms of supporting their grandparents, be it by cooking, cleaning or taking them to the nearby hospital or clinic.

Chapter Eight describes the children's experiences in the study in terms of the changing notion of kinship, where close kin relationships are formed outside the normal biological family boundaries because of the health and illness effects of losing parents and the overburden of already extended family households. The children's narratives express these new ties and relationships beyond the normal kinship system and reveal a constant shift of the notion of kinship, due at least in part to the lack of governmental support systems in the country and the effects of this on this small village community. Chapter Nine follows, tracing the orphaned children's severe losses and subsequent trajectories through health and illness and their survival tactics within the new households through labour, and economic and reciprocal activities. Although these activities are strongly criticised by local media, the change in children's daily health and illness situations from losing their parents requires them to take charge of their own lives and find ways and means to sustain themselves and other family members, while planning for their future. I also show how out of limited opportunities, care work, and household labour the children build positive imagined futures

and hopes for a better life ahead. I conclude by arguing that a holistic, multi-layered, socially situated and child-centric approach is needed when it comes to understanding the agency of children in the domains of health and wellbeing.

CHAPTER TWO

Theoretical conversations: Agency, childhood and wellbeing

This chapter reflects on the theoretical arguments that underpin this thesis. These theoretical tools allow me to argue that childhood cannot be confined to a singular trajectory or explanation. This chapter outlines key anthropological theories of agency, childhood and health, arguing that by focusing on the lifeworlds of children and their own explanations, we can critically develop the broader anthropological concepts of agency and health.

Theorising agency

This thesis draws a connection between multiple layers of agency, in relation to health and illness, revealed by the young participants from a small northern Namibian village. To do this goes against the grain of many popular visions of childhood. Claudia Castañeda (2002) explores how the "figure" of the child is brought into being in relation to diverse social and cultural spheres. The figure of the child, she shows, is malleable in what it comes to signify, remade by adult worlds for particular purposes and projects. Childhood, she argues, is often used to signify wider cultural concerns, which can silence the real concerns of children themselves. As expressed by Roy Grinker (2004, 856), a child is commonly portrayed never as "an entity in and of itself, but always exists in the service of some other subject. The lack of children's self-representations makes it all the more difficult to conceive of an alternative figuration of the child." The work of Castañeda (2002) encourages us to conceptualise children beyond practices and discourses that make them simply passive, innocent products of their environment or wider political forces.

In theorising children's worlds and actions, I turn first to the work of Sherry Ortner (2006, 139) who defined agency in two ways: as "intentionality and the pursuit of (culturally defined) projects" and as "about power, about acting within relations of social inequality, asymmetry, and force." Ortner (2006, 139) makes the point that agency "is never merely one or the other. … [It has] two 'faces' – as (the pursuit of) 'projects' or as (the exercise of or against) 'power'". In the case of this research, children exist in-between the pursuit of

projects and the exercise of power. The two-fold description of agency offered by Ortner (2006), and influenced by Raymond Williams (1977) and Clifford Geertz (1973), demonstrates agency being both "created" and "constitutive" of history and society. This theoretical conceptualisation of agency aligns with Ortner's (2006) description of culture as being both limiting and empowering of the individual. Ortner's (2006) ideas of agency are particularly applicable to this thesis, as she contrasts a western perspective of children (innocent, playful, carefree, dependent), with various non-western perspectives in which children must actively contribute to the adult world. The young participants in this research are required by extraordinary situations to act as agents, empowered also by the desires and aspirations that emerge from their daily circumstances. However, even as they do so, there is an implicit social contradiction here, in that the children are not meant to challenge the authority of adults, and must show absolute deference to them. As one of the children in the study related, she felt children were perceived by adults as "having nothing between their ears." Nonetheless, their situation as the only people capable of taking responsibility within the existing dilemmas of health and illness demand that they act and exercise their (invisible) power, within the numerous societal constraints of having a lesser voice and being perceived (as children) as incapable of exercising agency. As Ortner argues, their lives involve navigating between powerful structures beyond their control and individual agency on a daily basis.

Children live within highly hierarchal power structures. In the case of the young participants involved in this research, they interact with people in authority in institutions on a daily basis – doctors, nurses, hospitals, clinics, caregivers, schoolteachers – and in order to achieve their goals must work around these various structures. Agency emerges as children work within these disproportionate power relations to realise their goals. Ortner (2006) explains that in such situations, there is agency both in domination and resistance: "People in positions of power "have" – legitimately or not – what might be thought of as "a lot of agency," but the dominated too always have certain capacities … to exercise some sort of influence over the ways in which events unfold" (144). Those (the "dominated") – the children in this study – who struggle against hierarchies (the "dominant forces") must create other means and ways to overcome this limited agency.

Children's capabilities to do so are noted by Anthony Giddens (1984), who argues that children being subjugated by adults or institutions still retain the capability to make a difference in their society and can become "culture-makers", both in theory and practice. Acting as "culture-makers" further creates spaces for the children in this study to ethnographically explain, through their daily experiences of multi-layered agency, their understandings of health and illness. The purpose of this ethnography will be achieved through the children's own narratives. What emerges from their everyday reflections, humour, chores, and tactics is that they do not passively internalise these discourses but are aware they have the potential to become "culture-makers."

Understanding agency as centred on individual will and desire, and as a force in contrast to structure, is however limited from an anthropological perspective. I thus take inspiration from Marilyn Strathern's (1987) ideas on "partible" personhood, where she argues that subjecthood and action are constituted through people's roles and relationships. Rather than another's actions simply constraining the individual will, relationality enables people to act at all. Agency is therefore not situated inside the bounded self, but constituted between selves. Strathern asks us to consider:

> How are people seen to impinge upon one another; how are they affected by others? Are persons the authors of their own acts? Or do they derive their efficacy from others? … [Agency] refers to the manner in which people allocate causality or responsibility to one another, and thus sources of influence and directions of power … The concept of agency does not simply set up the question of whether people can know or determine interests for themselves, and thus whether individual wills are crushed, bent or expanded. It demands explicit attention to the contexts in which will is relevant to action (Strathern, 1987, 23).

In another context, Strathern (1988) observes that "objects" are created not in contradiction to the person but "out of the person". Therefore, the act of giving a gift represents not simply a symbolic gesture between one person and another but it is "extracted from the one and absorbed by another." However, gifts need not necessarily

only relate to material objects. In my study, children give of themselves in terms of the care and sacrifices involved in the huge roles they play in caring for their siblings, grandparents, and other family members, often in the absence of their own biological parents. As I will show in Chapter Seven, these relationships are forged between orphans who form bonds and identities as 'sisters', and extend similar relationships to neighbours. Emerging out of shared experiences, I will show how loss and responsibility became the substances that made kin out of these children, relationships that enabled new ways of thinking, being and doing. I therefore want to emphasise that children in this study must not be seen exclusively as individuals in pursuit of their own interest or in increasing their own abilities and influences over their environments, but rather but as parts of "collective bodies" as argued by James Laidlaw (2000). Indeed, their very goals, dreams and sense of volition are emergent out of (rather than in contradistinction with) the networks within which they are enmeshed.

I am further influenced by Laidlaw's (2000) understanding of agency and *responsibility*. He argues that, in contrast to Ornter, agency "is not an inherent quality of which individuals may have more or less but as an aspect of situations in which people may find themselves, and how this effect is created by attributions of responsibility" (147). Laidlaw shows how agency revolves around practices and events through which we are charged with responsibility, accused of being responsible, or through which we are able to take on responsibility, that create "relations that reach both into and beyond the individual." (163) Laidlaw's (2000) argument helps us to see agency within situations where children appear burdened by chores, tasks and practices of care, which they have not necessarily actively chosen. Finding ways to act involves children navigating all of the responsibilities for their grandparents, siblings, and neighbours in the context of insufficient and stressed forms of support. During the ethnographic work, the children's narratives included promises made to their late parents to look after their siblings and take care of their grandparents. Thus sustaining the community becomes the "cultural project" (Ortner, 2006, 139), as well as the individual project.

My argument is also underpinned by Michel Foucault's (1984) understanding of power, which has parallels with Laidlaw's approach. Foucault (1984) argues that power is not

owned, nor is it a possession or even something attached to a certain situation; it manifests in micro, often unseen, everyday processes (cf. Lupton, 1994; Petersen & Bunton, 1997). Power thus is primarily not overt or normative, but is generative of selves and society, powerful because it is seen as productive of the good life and voluntarily offered (Foucault, 1984). Foucault's (1984) idea of power links with Laidlaw's (2000) concept of responsibility because both are generative, whereas Ortner's (2006) idea of power is to some extent *a priori*; that is, the pursuit of "cultural projects" is framed within already established structures. Ortner's (2006) sense of power is to further a means to an end, whereas Laidlaw (2000) and Foucault (1984) speak of the generative and diffused dimensions of power that become part of people's life projects.

The work of James Scott (1985), on resistance and the "weapons of the weak", also offers some relevant insights, and I will draw upon his theories in terms of the connectedness of "hidden" and "invisible" modes of power, which often are revealed in "hidden transcripts", secret and covert means of expression and action. Scott argues that in order to "grasp potential acts, intentions as yet blocked, and possible futures that a shift in the balance of power or a crisis might bring to view, we have little choice to explore the realm of the hidden transcript" (16). In my study, the young participants often quietly expressed feeling constrained by political, economic or social forces. One of the strategies they used to deal with their limited options was to develop plans and practices that were largely socially invisible because of their status as children. Part of these strategies depended on secrecy, keeping quiet, and not attracting attention, in order to pursue their goals and work around hierarchies of asymmetric power. They also had to operate within the deliberately invisible practices of concealment that are part of issues of health and sickness in Namibia.

Therefore, the children in this study bring insights from their daily experiences of coping and resisting in circumstances where voice and visibility are severely limited. My focus on resistance also draws upon the work of Michel de Certeau (1984) and his notion of "tactics". Tactics reflect the unexpected ways in which people with limited power challenge, alter and change daily settings over which they have little control. In different situations and different arenas (such as hospitals, clinics, schools and within their households), I will show how children's agency is always shifting and contextualised, as tactics for coping shift and are adjusted depending on the opportunities within which children see to manoeuvre.

Managing different relationships required the young participants to take differing tactical approaches, whether those relationships were with me as the researcher, or with grandparents, caregivers, teachers, doctors, nurses, or in their relationships with each other.

Overall, I utilise these theorists to propose that children have multi-layered agency, that sometimes reflects acts of will power and resistance, while at other times indexes acts of faithful duty, and cultural notions of familial responsibility. Agency can reflect both individual dreams and aspirations, as well as the ways in which the self is always relationally embedded and constituted. Agency can both consolidate power and hierarchy at the same times that it can challenge it. Throughout this thesis I will show how children's agency shifts between these various forms, and how sometimes these different versions of agency are simultaneously present.

The anthropology of children and childhood

By focusing on children's own perspectives, the anthropology of childhood reveals children's wide ranging capabilities and how children are able to conceptualise risks and opportunities and to make thoughtful decisions about their lives (Prah, 2013; Abney, 2014; Cole & Durham, 2008). The work of Margaret Mead (1928) in Samoa and Bronislaw Malinowski (1961) in Melanesia in the early 1900s laid a firm foundation of studying children and childhood within different societies and, despite criticism, were ground-breaking in opening up discussions for a primary focus on children and childhood, and for critiquing the notion that the child is a universally cohesive category, acknowledging the diverse ways in which children live and are socialised around the world (LeVine, 2007).

The anthropology of childhood has also reveals how the categories and practices of childhood have changed over time. Robert LeVine and Rebecca New (2008, 11), in reviewing the history of the childhood and children, pointed out that the second part of the 19th century was a period when huge campaigns were launched by the media and other agencies aimed at "child-saving". This transformation process of the concepts of childhood and children formed part of an assertive effort to improve children's lives through education, health, social services, nutritional advances and the overall improvement of child wellbeing (LeVine, 2007). The effects of putting children first were further embraced by academics, as

the media and civil societies put children to the forefront of discussions (Hardman, 2001; Woodhead & Faulkner, 2008).[21]

Robert LeVine (2007) has criticised the disproportionately high amount of research on children taking place in the United States and other developed countries, when in 2000 more than 88 per cent of primary aged school children lived in developing countries. As noted by Sandra Evers, Catrien Notermans and Eric van Ommering (2011, 3) in Africa, where there is not yet a large body of childhood research, children have mainly been portrayed as sufferers and not capable of showing agency in actively and innovatively dealing with their challenges. The development of the more agent-focused anthropology of children and childhood studies only emerged in the late 1990s.

The work of Heather Montgomery (2009), David Lancy (2008) and Robert LeVine (2007) gives a concise overview of ethnographies which marked the start of early children and childhood discussions in anthropology and concentrated on child abuse, initiation and rituals, education, care, migration, relationships and participation.[22] The discussions of childhood anthropology advocated strongly for the focus on children's own voices, especially in the African and southern African contexts, and the focus of methodology and ethical considerations changed, shifting from giving explanations *about* children to focusing on children's own social lives and environments, with children themselves as the main participants.[23]

[21]This focus on protecting the "innocence" of children thereby radically helped children from being oppressed, in terms of child labour and economic exploitation, and supported change towards the establishment of rules and regulations enforcing compulsory schooling. With political pressure around the world advocating vigorously for children, various commitments and celebrations started, including the International Year of the Child in 1979, followed by reaffirmed commitments through the 1989 UN Convention of the Rights of the Child. See the work of Burman (1994) on a discussion of the shortfalls of the 1989 Convention on the Rights of the Child model in terms of the westernised perception and therefore the exclusion of children having various challenges in terms of resources and socio-political constrains. Henderson (1999), Caputo (1995) and James and Prout (1997) are various child researchers who are further of the opinion that this model only related to the "perfect child" and therefore recommended children's own voices and experiences and not advocated through "thrice filtered sources".

[22] For further discussions on the children and childhood discussions see the work of Hardman (2001), Stephens (1995) and James and Prout (1997).

[23] The studies of van Dijk (2008), van der Brug (2007) and Notermans (2008) are all studies that further contributed to theoretical insights and change with regards to children's voices and representation.

The ethnography of Kate Abney (2014) dealt with children's experiences in a TB treatment facility in Cape Town, South Africa. She traced the lives of children in an institutionalised hospital facility, listening to their narratives and taking a more nuanced approach than just exploring how the disease of TB still loomed in the modern health era. She concluded that experiences of TB and childhood could never be "experienced" anywhere in the world in the same way but, through ethnography, we were allowed to understand some of the differences that made each experience distinct. Another ethnography, conducted over three years by Efua Prah (2013) amongst children in South Africa, highlighted the difference that an ethnographically focused study might achieve in examining the impact of violence on society, embodiment and childhood. Prah (2013) traced the lives of children who had been displaced to different areas of Cape Town. The researcher managed to capture the children's ideas on health and wellness through their own performances and drama ideas, which provided insights into the children's daily experiences of kinship, love and violence and what it was like for them being part of a community fuelled by drugs, gangster activities and other conflicts. Both Abney's (2014) and Prah's (2013) recent work are examples that demonstrate how children's lives are inseparable from the political, economic and social worlds that are dominated by adults; however, their lives are just as much affected by these forces. Furthermore, these studies indicated that children are fully capable of having their own nuanced and complex ideas and perspectives about such wider forces (James & Prout, 1997). Both of these ethnographies highlight children's "multiperspectives" or "multivocality" in the healthcare environment.

Myra Bluebond-Langner and Jill Korbin (2007), in their anthropology of childhood research, demonstrate a commitment towards treating children's ideas as an "emic view" and therefore listening to the children themselves as individuals with the authority of their own experience, experts within their own particular cultural and social context and active agents in decision-making and the behaviours they choose.[24] In this research, I engaged in a similar

[24] This approach reinforces the arguments made by Anne Greig, Jayne Taylor and Tommy MacKay (2013, 96), that hearing what children have to say is one of the most ignored aspects within child research and therefore inviting children to become participants in that research allows utilisation of the influence their ideas might have on the research as a whole. In this manner, the research is strengthened as children as participants have the best knowledge of their own situation. This knowledge further validates the researcher's understandings,

approach and my young participants provided valuable insights into their immediate and current social worlds and demonstrated that they were capable of both dealing with their daily constraints and reflecting upon them. As asserted by Montgomery (2009, 5),

> Children and childhood are now generally recognized as being worthy subjects of study, and it is no longer possible to agree with those who make the claim that children are not taken seriously in anthropology or that those who study children are not taken seriously as anthropologists.

There is still a dearth of anthropological studies of children and childhood not only in Southern Africa, but more specifically in the Namibian context, with even fewer studies where children were specifically included as the main participants in the study. My current research is therefore intended to contribute to remedying this lack and further to demonstrate that children in the Namibian and wider African context need to be considered more explicitly and valued as key participants in research. My research did not merely record their ideas, experiences and understandings of health and illness; it went beyondthat, allowing the young participants to be partners in the research, negotiating the research methods, and shaping the questions that became important to my study.

Medical anthropology and children

Despite the expansive scope of medical anthropology, there remains a lack of discussion of the intersection of the anthropology of children and childhood with medical anthropology. I thus wish to connect central concerns in medical anthropology, such as patient/medical actor conflicts, access to care, and culturally appropriate healthcare measures (e.g. Singer & Baer, 2007) to the anthropology of childhood, to see what new insights might be proffered. This focus has a very real practical utility. This research will I hope allow medical professionals, health policy makers, doctors and nurses better insight into the challenges and resiliencies that children face in being agents of wellbeing in their communities.

with the children actively taking part in research activities themselves or highlighting some of the gaps that may exist within the research.

The ethnographic study by Grace Akello-Ayebare (2008), on children's suffering during the ongoing civil war in Uganda, is one of few childhood anthropology studies in Africa which focus on the public health terrain, demonstrating where childhood and children's studies can make a difference. Her study provides important health information on the children's suffering, their understandings of illness and how they managed to cope through medicine and other mechanisms. From this data, Akello-Ayebare (2008) made policy recommendations on the "right to health." Her ethnography demonstrates that children have a greater role to play in medical anthropology. As observed by Fiona Ross (2010, 169):

> So much and yet so little is known of how people make sense of daily life in the face of illness, or about its impact on accustomed modes of sociality and ordinary ways of relating. It is here that medical anthropology, with its commitment to local worlds and fine grained social analysis, has much to offer.

Christine Dedding and colleagues (2014) attribute this absence in the literature to attitudes that children for the most part need to be represented by adults in health environments, and that children's own ideas would not provide a unique perspective beyond that of the normal adult interpretation. This notion of under-representation is further noted by Tony Binns, Alan Dixon and Etienne Nel (2012), who pointed out that there has been greater awareness of children's health issues, but not a concurrent awareness of children's perspectives. Yet children do offer something different. They often talk about health issues more spontaneously than adults and can be more aware of certain issues because their own bodies, and their fragile control over them, can be of great personal concern to them (Bush et al., 1996). Yet in Africa there is are particularly acute silences on these topics that have been mimicked by medical anthropology.

Children offer us one vantage point into understanding how the meanings of health are set within distinctive individual, family, social and cultural arenas and can differ extensively in different places and over time in the same place. Arthur Kleinman (1980) observed that illness includes the perceptions, understandings and responses of the sick person, family members and their wider social circle. Furthermore, it also includes how people cope with

any physical bodily distress and how the patient explains and evaluates the significance of the illness and makes decisions about living with and coping with the illness. As I will show, children's understandings and actions are central, and often pivotal, to all of these domains in northern Namibia.

Children's understandings of health and illness are also shaped by processes that teach them to become biomedical citizens (Petryna, 2002; Rose, 2007; Decoteau, 2013; Biehl,

2004), at their local schools and clinics, and the children integrate what they are taught in school with their knowledge of traditional medical practices and beliefs. The concept of biological citizenship, the process by which citizens are engaged in the process of improving the health of the nation, and the state becomes invested in enhancing the vitality and wellbeing of its citizens, has been increasingly important to medical anthropology in recent years. Yet the role of children as biological citizens has not been theoretically explored in any depth. Grace Spencer, Marion Doull and Jean Shoveller (2014) highlight that children can be both passive recipients of information and active agents meeting demands, engaging in activities, and contributing to their own development with regards to health. In this vein, my study offers a holistic awareness of the local health worlds of children, made up of a wider health community which includes information, ideologies and practices received from or advanced by doctors, teachers, the state, local healers and members of their own family, with whom they are in daily contact and who they ultimately serve.

Conclusion

In sum, this chapter has highlighted the core theoretical ideas that underpin the analysis to follow. I show that agency has multiple dimensions, and thus the concept of agency is best conceived using multiple theoretical vantage points to bring out its varied possible manifestations. This approach is particularly important in studying children, whose subtle ways of negotiating social worlds has often been rendered socially and academically invisible. In calling for a central place for children in the medical anthropology literature of southern Africa, my work seeks to not only chart their agency, but also help to spotlight and support it in the realms of healthcare and wellbeing through giving it voice and academic prominence.

CHAPTER THREE

Methodology: ways to listen to children

Introduction

In this chapter I describe earlier fieldwork and experiences which strongly motivated me on a personal level to conduct my doctoral research. This prior experience also explains why I chose to work with children in this particular study. My opportunity in 2001, volunteering in an anti-retroviral (ARV) clinic, led me to pursue a different line of research, not just inside institutional domains, but taking a multi-layered agency perspective of children's everyday lives, as surrounded by health and illness challenges in Namibia. I then describe how I developed my doctoral research, and the methods I chose to gain insights into children's experiences and perspectives.

For me, this beginning began back in 2001, while I was involved in voluntary work at an ARV clinic in the capital city of Windhoek in Namibia, as a follow-up to my Master's studies. I had been involved with the ARV clinic previously and this voluntary work was a way of giving back to the community with which I had worked. I observed that some children infected with HIV/AIDS (CIHIV), visiting the clinic for their regular check-ups and medication, were desperately in need of someone just to talk to about their own health situation, to start a dialogue with someone who they could trust, in order to express with their own voices what they knew about their own health and illness. Comparing their health status (as sick children infected with HIV) to their healthier counterparts (friends at school and home) was a continuous concern for them. My normal conversations would begin, "How are you today?" and they would reply with a sad face, avoiding eye contact, "I do not feel well and I do not know why." I would continue the conversation, ask if they would like to play a board game or do something else to distract their minds, and some children would agree. Others would continue to ask questions.

These children in the local ARV clinic might have had their own ideas and interpretations of what it meant to be healthy or ill, but I was not in a position to ask them or to answer any questions about their own situation in terms of health and illness. I felt helpless. I was not in

a position to answer any of their questions because of the ethical agreement I had with the local hospital and clinic, so most of the time I avoided their questions by changing the subject. My function was mainly to keep the children occupied, while their mothers, aunts or guardians took their own medication or spoke with the medical personnel at the clinic. In fulfilling this task, my experience as a mother came in handy, preparing lunches and packing picnic baskets for the children and later, as relationships developed, giving some of my daughter's clothes to those in need. I soon realised that these children needed much more than just me to look after them, to play and interact with them for a few hours, and they definitely needed more than just a picnic basket and odd clothes. On numerous occasions when leaving the clinic, I felt useless, hopeless and completely puzzled and perplexed. In the work of Nancy Scheper-Hughes (1992) with women and children in shanty-town Brazil, she explains that as an ethnographer (or, in my own situation, what I would call someone who accidentally stumbles into the lives and worlds of others so much so that it is difficult to leave), the only way out is through our research and ethnographical writing:

> The act of witnessing is what lends our work moral (at times it is almost theological) character. So-called participant observation has a way of drawing the ethnographer into spaces of human life where he or she prefer not to go at all and once there does not know how to go about getting out except through writing, which draws others there as well, making them party to act the witnessing (Scheper-Hughes, 1992, xii).

This description of participant-observation highlighted by Scheper-Hughes relates to my situation at the ARV clinic in 2001 – and never again do I want to feel so helpless. My personal relationship with one particular boy in the clinic made me realise that far more needed to be done than just one person coming to the clinic every fortnight for a few hours. Seeing him (unknowingly) for the last time before his death, his squeaky voice struggling for breath, even as he smiled, he asked me the question, "Why am I always sick? I am worried about my school work, and about my aunt that needs to come with me on regular hospital visits." Reaching out to me and touching my hand, he posed a final question, "Why am I so thin?" This was the voice of an eleven-year-old boy in his pyjamas at an ARV clinic. I thought

to myself, here is yet another child living with a fatal, chronic disease, that wants to give expression to his feelings and is grappling for answers.

There were many elements of this boy's story that I did not know, and although I cannot say I feel I redeemed myself fully, my current fieldwork gave me the opportunity to have better, more meaningful conversations. In my current fieldwork in the northern part of Namibia, I was able to hear what children had to say about health and illness; to see and understand the roles they played in the health and illness arena; to listen to their own ideas, their worries and concerns, their own opinions and solutions to health and illness situations. Irrespective of whether they were healthy or ill, their answers gave me insights into their own perspectives and the multi-layered agency of children's everyday lives in this northern Namibian town.

Research ethics: The ethics process and approval

This study was approved by the University of Canterbury Human Ethics Committee (Appendix A) and the Ministry of Health and Social Services in Namibia (Appendix C), and these two approval letters granted me access to the key gatekeepers, the local Village Chief, School Principal, and local clinic and hospital staff.[25]

During my research, I discovered that ethics approval differs in many ways in different contexts. Academic committees from my university required that several copies of the detailed ethics application document were made, each to be carefully scrutinised by esteemed academics, who then returned with yet more questions to be answered. At the governmental level in my own country, Namibia, I realised that the process was not in any way easier. I had to deal with the Ministerial Ethics Committee, whose members were frequently out of the office due to other commitments. I agonised over the long, painful waiting periods – but waiting a long time for ethics approval is not uncommon. Not much in

[25] The village where I stayed had a village chief who was in charge of all the homesteads in the area and when there were major concerns like drought or floods (both of which occurred during the period when my study took place), the village chief was the one consulted by local government. To get entry into the village, I had to petition the village chief, who granted me permission to enter the village and also introduced me to a small group of woman who served as his counsellors. All the counsellors of the village chief came from different homesteads in the village.

anthropological literature is written about the timeframe of the above-mentioned processes, but approval processes can eat into research time, particularly when your time in the field becomes limited due to funding and other obligations.

Kate Abney (2014), in her ethnographic study of children on a TB ward in Cape Town, focuses on two types of processes when it comes to ethics. She describes the first process as a "formal ethical paper trail" where you, as the researcher, need to adhere to the formal processes of various institutions, other bodies and gatekeepers, in a process explained by her as "highly codified." However, Abney regarded the other process - the "informal ethical process" - as more significant because it deals with the actual "doing" of your research. In this "doing" there are times when it is expected that, regardless of your role as a researcher, you will be ethical as a person. This expectation, which takes the focus away from formal ethics procedures and from the professional to the personal, arises when you need to deal with various ethical challenges in the field. At various times and stages during my study, I had to respect the answers of the children participating in the study when they just avoidedanswering a question and suddenly spoke about something totally different or just kept quiet. They shared many private conversations with me that I felt could not be recorded and used as data or mentioned in the current study. I never went to their homesteads without being invited and it was only at their request and with their permission that I would walk alongside them in the village, share a meal or attend a church service or other ceremonies. Individual interviews were recorded, taking place on several occasions, and they could come back at any time to listen to the recordings and delete any conversation they felt uncomfortable with.

The 22 school children who were majority of the young participants in the study were approached and selected from the local primary school where the afternoon contact sessions took place, while the four non-school attending children were identified through rounds in the village with the TB volunteers.[26] A more detailed outline explaining how the

[26] The TB volunteers are local women and men that have had limited training to enable them to work in support of the professional nurses and doctors in the local clinics. The volunteers go out into the local communities and see to the day to day needs of out-patients, particularly those who are bed-ridden, administering medication and monitoring health. The scheme was arranged through the Ministry of Health because of a shortage of fully qualified medical personnel and will be further discussed in Chapter Three.

non-school attending children came to be part of this study is given in the section titled 'The working orphans' and in detailed discussions in Chapters Six, Seven and Eight.

Written and oral permission was sought from each of the 26 children involved in the research and, from the start of the study, all of the children were briefed in detail about the purpose of the study, the timeframe of the study, interviews, home visits and incentives. The children in the current study were constantly reminded about their right to withdraw from the study at any given point and advised that, if they did so, all the information previously gathered would be destroyed.

Some of the children who I approached told me that they could not participate because they lived too far from the school, while others indicated that their daily responsibilities after school would not allow them to commit to the study. With a school of more than 600 learners, it was not too hard to get children to participate but it must be mentioned that it became very hard to exclude others that wanted to participate after the total number of 22 children was reached. This exclusion led to various frustrations and, at the start of my study, the school leaders demanded that I explain myself to the whole school at their morning devotion, particularly the reasons why I could only include 22 children. As all the children in the study were under the age of sixteen and under the current laws legally seen as minors, it was also demanded that their legal guardians or parents had to give permission for each of the children to participate (see Appendix F). In Chapter Five, where I discuss stigma and visibility, some of the difficulties I encountered with the gatekeepers are discussed in detail. There was a local social worker and psychologist on standby for counselling and review during the duration of my entire study, in case any of the children became distressed. However, throughout the entire study there was no incident or discussion from which it was deemed necessary that the children needed counselling or referral.

Children's anger about the formal ethics procedures

Michael Akuupa (2010, 22), in his study on the formation of a "national culture" in post-apartheid Namibia, relates the ethical difficulties and confusion that currently exist with

regards to visual materials gathered in the field in Namibia, and notes that there is clearly no consistency in dealing with this type of material. As part of the ethics agreement with the Namibian Ministry of Health and Social Services, I was prohibited from taking any photographs of the children in the study that would identify them or show their faces. However, the children involved in the research became very angry when I showed them some of the pictures taken during the participatory events in class and felt they were not fully represented and did not wanted to be seen as "faceless". An excerpt from my field notes describes their reaction:

> I am happy to share and show the children the pictures I captured during one of the participatory methods. I could immediately sense Messy's disappointment, when he realised that none of the photos included their faces, upon which he challenged me with a question, "Where are we in these photos? It's not us but our behinds and faceless bodies." This provoked others, and Moricia, standing next to Messy, took this opportunity to add her opinion that she felt that the photos were ugly and did not show how they really were. She further explained, "Because my face is who I am and this is our experience and our work, so we want people to see who we really are." I try to defend the procedure but the children seemed to think that decisions taken beforehand were unfair and did not consider their opinions. I asked Moricia what she thought must change. She first looked at me and after a while answered, "We are human beings and have rights and I think we need to be on that committee you are talking about and talk to all of those people ourselves and tell them how we feel."

The arguments of the children were indeed a key concern for me, as the researcher, because while I adhered to all the requirements of the individual ethics committees, because of this the requirements of the children in my study came to be neglected. Due to my own time restrictions, and the constraints and lack of availability of the Ministerial Ethics

Board in Namibia, it was impossible for me to make a re-submission, asking permission with the consent of the children themselves to show their faces in the pictures taken in the field. This was a valuable lesson learnt for any future research with children in Namibia.

Research with children is a "minefield"

Even before applying for ethics approval, my own experiences in discussions with several of my colleagues in both Christchurch and Namibia is worth mentioning. I was told that I was stepping on a "minefield", as colleagues raised their eyebrows and asked questions like, "Would adults not be easier?" I was very mindful of all the comments made and must say that at one stage I became a little bit rattled, particularly when I considered all the comments together with the extensive restrictions imposed by the actual ethics committees. My experience sheds light on huge ongoing debates about the place and space of anthropology as a discipline and how anthropologists must take places on ethics committees for others to understand our research and to allow better functioning of our fieldwork. Similar situations to mine are referenced by Emma Kowal (2014), writing about her work with indigenous communities in Australia, when she argues for representation of anthropologists on various ethics committees as "Anthropologists need to be at the table."

This is especially the case with childhood anthropology. I would go further, having heard and seen the children who participated in my own research, and say that in terms of the anthropology of childhood, children need to be at the table as well. In order for ethnographically grounded approaches to be better understood, our involvement and representation on ethics committees is vital. There were no anthropologists on the ethics committee at the University of Canterbury or in the Ministry of Health and Social Services in Namibia at the time that my ethics approval was granted. As mentioned by Efua Prah (2013), in her study of children living in temporary relocation camps in Cape Town, at the point of entering the field and working specifically with children, we must be constantly reminded that "ethical debate on the processes and procedures of [working with] children is ongoing" and, while this process is continuing, we must not stop doing research with children or shy away from giving children a rightful place in research.

Background: Connection and reflection in the field

When I conducted my fieldwork in northern Namibia, I stayed in the village with one of the local families. At first, when I finally got all the required paper trails behind me, the school principal offered me a place in one of the teacher's houses on the premises of the local primary school where I conducted my study. I had to decline the offer because I had already made prior arrangements with a family before coming to the area. At later stages of the

research, I was very happy that I had made this particular decision, because staying with a family brought me so much closer to the lives of the children and adults in this particular village. Soon after beginning fieldwork, I also realised that if I had opted to stay at the teacher's house, it would have created a greater power imbalance between myself and the children because I observed that the children barely spoke directly to the teachers. Staying with a local family made me more visible in the village and gave me access to the children in day-to-day interactions. The children would randomly come to the homestead and invite me to take a walk to the clinic, share their herding experiences, show me where they caught fish in the rainy season or just take me around the village, laughing and playing. I also became the local transporter on call – taking the elderly to receive their monthly grant from the

state, transporting some of the sick to the local hospital, loading up water from the nearby waterhole to be delivered to individual homesteads and every morning going to school with an overloaded pick-up full of school children who had hopped on along the way.

In many ways the people of this local village expected nothing in return and sometimes I would gladly have accepted it if they had demanded more; however, in these small ways

I could give back to this community because at numerous times I felt I took so much from them, being an uninvited intruder in their lives. I realised ethnography gave me the opportunity to come into this small village and listen, observe, laugh, cry in my private moments, play and follow children's stories in a way that would otherwise would have been lost.

"Volunteer and no pay?"

Catherine Trundle (2014, 4), in her work on migration and charity, highlights the advantages and challenges of being a volunteer. She explains that, as the ethnographer, being a volunteer gave her an opportunity to easily enter the field, be of use, and use volunteering as a "point of entry" into the community. After meeting and being introduced to the staff at the primary school, I was informed that a few teachers had taken up other positions before the holiday break and their replacements had not yet arrived. I then opted to volunteer by teaching for six weeks until the new teachers arrived. The school principal was extremely happy with my decision and was quick to ask, with a big question mark on his face, "Volunteer and no pay?" Using volunteering to establish myself as a researcher in the local

school community gave me the advantage of familiarising myself with the local primary school and eventually, after those six weeks, of being able to select participants for the study. As further stated by Trundle (2014), and as she was told by her participants, "enthusiasm was the only prerequisite." For me, I saw this as an opportunity to help, because I had some spare time during the first half of the day and, in any case, was just keen to lend a hand in an emergency situation.

The reaction of the school principal was not unfounded, because volunteering is a westernised concept and, especially in Namibia, the concept of volunteering is attached to foreigners or people coming from abroad, because volunteering is regarded by locals as a luxury or, as in a remark made by one of the teachers, "You must be rich to work for nothing." Being a volunteer teacher at the primary school was not just restricted to teaching the set school curriculum I was handed that same day. Familiarisation with the school system gave me various opportunities to become part of the whole school community and, most importantly, to meet the children, watch their interactions with each other and observe the power relations that existed between themselves and the school staff. There was no confusion about my role at the school because the school principal was very happy and grateful, introducing me the following morning at their morning devotions as a researcher and also explaining that I had opted to become a volunteer teacher due to the absence of the replacement teachers. As part of initial participant observation, during lunch breaks I preferred to sit with the children outside and not with the staff. Eventually the children would take me around the school grounds to meet their friends, see their playground and just walk with me around places at the school they felt I needed to see. I started to share my lunch with the children and they in turn would bring me some of the fruit they grew at home.

Trundle (2014, 5) suggests that volunteering has its advantages and disadvantages and, in my case as an ethnographer, my role was not always accepted or well understood, especially by the staff when they became angry and unhappy with me for spending too much time with the children. Because of the perceived hierarchy of teachers, taking a top-down approach, they would sometimes chase away the children sitting alongside me, making remarks like, "Why do you have so many flies around you?" Such actions served to

further remind me of the distance I needed to keep from the teachers. I had to explain to them that my research dealt with children and, as much as they felt the children would take advantage or as they said, “Disrespect me”, it was important for me to be trusted and to get to know them. The school staff eventually realised that the children did not see me as the equivalent of a local teacher but mainly as the “volunteer teacher.” The term “volunteer” was known to the children because of the Namibian government’s agreement with the United States, which results in American Peace Corps Volunteers coming to rural schools on a regular basis, providing services in health, small enterprise, and youth development programmes. These children knew that I would only be at the school for a certain period and saw me as the ‘outsider’ with whom they could crack a joke, laugh and have the odd gossip.

Participant-observation, field notes, individual interviews and home visits

Participant-observation is a key part of ethnography and notable for its depth, intensity and flexibility (Herbert, 2014). Throughout my fieldwork, participant observation was the primary method, which allowed me considerable insight into the lives and interactions of these children, around the village, at the waterholes, along the road, at school, and at the local clinics and hospitals. I had various conversations with clinic nurses, traditional healers, and doctors, who I would consult for additional information about the health system, children’s interactions with it, and the role of the children in the health system itself. I would also talk to the parents, caregivers or guardians of the children during my pre-arranged home visits. All the final interviews and discussions (after introducing the participatory methods after school in class) took place with the children on an individual basis, as requested by them. As agreed, almost all discussions were recorded.

At first the children were very anxious and uncomfortable talking while being recorded and took a little time to familiarise themselves with being recorded. I then decided to turn the recorder off, show them how to operate it themselves and then, when they felt the recording should start, they could turn it on themselves. When they took control of the recording, they felt more at ease and the fact that they could come back several times after any recording had been made, to listen and (should they wish) to delete some of the conversation, made the recording process much smoother. The home visits enabled me to

compare their discussions during our time in class with their individual circumstances and place some of their experiences in perspective.

Coming out of the field and analysis

In anthropology, data analysis is a continuous process which forms part of daily participant-observation. In listening to the children and constantly reviewing the data, I refined and reformulated my research aims. It was deeply overwhelming to come back to New Zealand with all the relevant data collected in two huge boxes (perhaps it was more the unpacking that was overwhelming and daunting). While my analysis had started in the field, looking again at the material and re-organising all the data I had gathered – including field notes, the children's open and closed health diaries, and the results of free listing and body mapping exercises – gave rise to identifying new threads of enquiry and themes in preparation for the writing process. Mike Crang and Ian Cook (2007) describe the purpose of this process of analysis:

> What this formal stage of analysis is supposed to do, then, is to reconfigure this data, to look at it more carefully and critically, and perhaps to de-and re-contextualise different parts so as to be able to see new themes and patterns. It is not a separate phase that takes place in a detached space. It's a connected and connective process … The themes that become such an important part of formal analysis usually start their lives in the data as it's constructed, then get scribbled on the margins of the data (133).

Back to the start

Facing the broken windows and tiny desks and chairs, I looked out into the vast flat distance of dusty, sandy roads, with huge palm trees, chickens, goats, cows, and donkeys near the school fence, and heard only the sound of the odd taxi trying to make its way through the sandy roads and leaving a cloud of dust in the far distance. I was all nervous and sweaty in the winter afternoon, in heat of more than 25 degrees, at the beginning of April 2013. The huge noise of the school siren signalled the end of yet another school day. As children started to make their way out from the school grounds, the animals desperately started to run away as they knew their peaceful day had also come to an end. With the huge noise of

the siren breaking the silence, I realised that this would be the place where I would remain after school and gather with the 22 school children who had become part of a total of 26 participants involved in my research. The 22 children were selected randomly from the classes in which I had taught during the previous six-week period and, although most of the children I approached accepted the invitation, a few informed me that they could not participate because they lived too far from the school and most had other duties. In terms of safety and security, most of the children who I approached had to be living within six kilometers of the school, which ensured that I was able to drive them home if they could not reach home before dark. The children who participated in my study were therefore mainly chosen on a basis of important practicalities, taking into account their willingness to participate, their availability and the distance they stayed from the school where the study took place. All the planned sessions with the children took place after the school day so as not to interfere with their regular school day. Our meeting place had been identified earlier in the day, at a meeting with the local school principal and guardians, which took place in a specific classroom on the school premises. I met there with the children for three days of the week, firstly for a period of six months and later followed by a second period of five months.

I immediately left what I had just observed outside the windows of the school building and turned my attention to the participants coming into the classroom, who began to fill up the desks. The 22 school children entered the classroom, carrying their bags. Some just had plastic bags from the huge shopping outlets on the periphery of the village, filled with books, while another had an odd, broken, black canvas schoolbag with a faded Spider-man sticker. Looking at these children eagerly sitting and smiling at me after a long school day, I suddenly reflected on myself as a school girl years ago. I felt a brief moment of both doubt and fear.

Suddenly excitement took over and all previous fears and anxiety seemed to disappear. From a brief conversation with some of the girls, our journey started, with the words, “We have a lot to tell.” I went and sat next to them, forcing myself into a small chair, and asked the group if one of them was willing to write the words on the faded blackboard. A girl stood up nervously and walked to the blackboard, with her big, black, glowing eyes staring

at the others. She bravely took the chalk from my hand, quickly ran to the blackboard, and wrote, “Health and sick = we have a lot to tell.”

The working orphans

Back in Namibia some months later, in the dire summer heat of more than 40 degrees over the November/December summer season, awaiting the summer rains, I fortuitously met a second group of children while going on rounds with the tuberculosis (TB) volunteers. The second group of children came from the same area as the first, but from a different location, away from the primary school where I conducted my fieldwork with the 22 school children.
I came to know them due to my discovery (after my first fieldwork period earlier in the year and after my return from Namibia to Christchurch) that there were children in the area that did not attend school, despite the assurances of the local school authorities to the contrary. During conversations discussing whether there were children in the area that did not attend school, the school authorities specifically told me, “*Meme* Rosa, do you see any child outside this school yard running around and not in class? Show me, because the parents will be in trouble because the Ministry of Education will put them in jail.’’ With great pride and authority, he had said, “It’s impossible because this village is small and it would be reported to me.” The principal’s persistent arguments had convinced me not to look beyond the boundaries of the school for other young participants and he had further explained that, with schooling being compulsory, the Ministry of Education’s new subsidised education plan and free schooling made his arguments even more convincing.

Following my first fieldwork period, I had returned to New Zealand, and I was reading governmental statistical reports on the Ohangwena area prior to my return for the second fieldwork period, and I reflected that the situation on the ground might prove to be somewhat different than that of which the school authorities had said. The arguments made by the school principal in relation to free and compulsory schooling were, however, similar to representations made to the anthropologist, Susan Levine, and reported in the findings of her work with children in the vineyards of South Africa. Levine (2000, 85) argued that although schooling was compulsory, it did not “change the economic condition of the poor children attending school” and the children on the wine farms needed to work to supplement the low salaries earned by their parents. For the second group of children in my

study (those who worked, rather than attended school), it was no different. Although the Ministry of Education provided free schooling for primary and secondary education, the daily circumstances of the four children in this second group still resulted in them not being able to attend school (see Chapters Six, Seven and Eight for detailed discussions). Having read various reports and realised that I might have been misinformed, I then became determined to find if there were any non-school attending children living in the school catchment[27] during my second field period,[28] to hear their insights and experiences and how those might differ from the school children's ideas of health and illness.

Returning to what happened on that hot day, I needed a break from the harsh sun and heat. I had returned from a very cold Christchurch only a few weeks before and had not yet fully made an adjustment back to the Namibian heat. When I saw two girls doing some washing under a big maroela tree, I stopped and asked their permission to sit and wait while the TB volunteers continued their rounds from one hut to another, handing out medicine to bedridden TB patients and caretakers. With the girls' permission, I put my hands in their cold washing water, and then joined them in their washing activity during which we began to converse. The volunteers came back from their rounds and whispered in my ear that those specific girls did not attend school.

I remained sitting with the girls and continued chatting with them and explained more about myself and my reason for being around the village. Upon that, both girls looked at me and the older one asked, "What makes you think we can help you because we are just doing washing?" She then looked at the younger girl and started to giggle. The younger one answered, "If it is health and illness you want to hear about we are 'nurses' ourselves", and pointing in the direction of the TB volunteers, she continued, "and we surely know a lot." As I looked at these two girls with shock, the youngest continued again, "You look surprised,

[27] The Ohangwena Region reportedly had 90 per cent of children attending school (Ministry of Education, 2011) but the *Population and Housing Census Regional Profile* (NSA, 2013) indicated that, from data gathered in 2011, 13.5 per cent of children (aged six years and above) had never attended school and 46 per cent had incomplete schooling, while 41 per cent of children (between the ages of seven and thirteen years old) had managed to complete school.

[28] In addition to the first Human Ethics approval, a second amendment letter was granted from the Human Ethics Committee, University of Canterbury, to conduct research with children who were not attending school (Appendix B).

Meme. Please come tomorrow and another tomorrow and we will show you and tell you that there is much to talk about when it comes to health and illness." The elder girl got up and covered the younger one's mouth, stopping her from talking any further, and looked frantically around to see if anybody had overheard our conversation, which gave all of us a big laugh.

The two boys I later met – who became the second two young participants of this group of four – were also from the same area as the two girls but from different households and I met them through a local nurse who lived next door to them. I named these two girls and two boys "the working orphans" because these children, who did not attend school, regarded themselves as children who performed activities similar to those of working adults (see detailed discussion in Chapters Six, Seven and Eight). After arranging permission from their guardians for these children to participate in the study, I met the four orphans[29] almost every day for five months at their homes and was involved with their daily caring and working activities.

The young participants

In the words of Susan Rasmussen (1994, 343), who wrote about her experiences and relationships with local children during her fieldwork in Niger, West Africa, exploring adult's understandings of children,

> In fieldwork, perhaps the most memorable interaction occurs between anthropologist and local children; this is usually true in small-scale rural communities, regardless of what "official" research topic brings the ethnographer into the field. Yet with few exceptions, this interaction remains hidden data – most of it relegated to field diaries, notes in margins, and letters home.

I am in agreement with Rasmussen (1994), although I have made sure that this data is not hidden or relegated to diaries, but is the primary focus of this thesis. As described by Patricia Henderson (1999, 21), in her ethnographic work doing research amongst youths in

[29] In this study, where the term 'orphan' is used, (as per the 2010 classification of MGECW) it means a child who has lost both one and both of their parents.

South Africa, this involves “giving each child a presence that is often lost in general forms of analysis and description.”

When I came to the area, not knowing anybody in particular gave me the opportunity to familiarise myself with the local culture as an “outsider”’ and therefore provided the advantage of not allowing me to disregard or ignore things that a local or a regular visitor might overlook. These short fieldwork descriptions remind me how I saw these children daily: coming to the after school sessions, during home visits, having a chat and eating together, walking with them to the local clinic or *cuca* shop. At these times, when these children became relaxed around me, they would speak softly in my ear, gossiping, or simply laughing together, or at times trying to avoid the heartache in their minds by not making any eye contact. At those times, I had to hide my own tears, being a mother myself. During the fieldwork period, in my experience, much is left in the hearts and minds of both the researcher and child participants even long after fieldwork ends.

All of the children who participated in my research lived in the Ohangwena Region at the time, but nine out of the total group of 26 indicated to me that they were not born in the region. They were living there due to various circumstances, such as their parents having died, coming to live with grandparents to assist them, or the working circumstances of parents living in the capital city or other regions that meant they could not live with them. Twenty of the 22 school-going participants lived with one grandparent. Of the remaining two, one was looked after by a housekeeper because her parents worked in a mine situated in the southern part of the country, while the other lived with his mother and siblings. The school children in the study were mostly in Grades Five to Seven and, at the time the study was conducted, all 22 school-going children were nine to twelve years old. The four non-school attending children had been orphaned and lived in the same catchment, just outside the village area, with families that were not biologically related to them. All four of them were also between nine and twelve years old at the time of the study.

No details of the health status of any of the 26 children who participated in the study were known to me and, although later conversations centred on the topics of health and illness (and it was statistically likely that in a group that size several of them were HIV positive),

none of them revealed that they were HIV positive or on any ARV treatment program. (See discussion of stigma and visibility in relation to illness in Chapter Six, for some of the reasons why the children may not have engaged in any discussion of HIV/AIDS). All of the children in the study were poor and heavily relied on the governmental feeding schemes at the school. The working orphan group children were dependent on the food given to them by their guardians, the TB volunteers (via the Ministry of Health), drought relief workers and their neighbours. Through their health diaries, the children indicated that their main meal was the evening meal. Most of them did not have any breakfast and could not afford to bring lunch to school. Irrespective of the lack of food and other basic necessities (such as wearing no school shoes, ragged school clothes and only having plastic shopping bags in which to carry their school books), the school children all looked reasonably healthy but were very timid for their age group. The four orphaned children also came across as being in good health on first impression, but looked more mature for their age group than the school children. This impression of maturity may have in part related to the fact that they regularly wore clothes slightly too big and of adult style, likely to have been hand-me-downs. Only three of the school children had vegetable gardens at their homes, the produce of which they used for the household and also sold some of the vegetables locally.

In all the classroom or individual discussions that were conducted, the children had the option to use their mother tongue but they mostly spoke in English and only sometimes when they got excited would they switch to their primary language. As I could only follow basic conversations in the local Oshiwambo language, the sensitivity and complexity of the individual discussions that took place necessitated involving an interpreter that knew the local language well. Having my research assistant alongside me also helped with the requirement of the ethics approval to have another adult with me throughout the research period. None of the children dropped out of the study during the research period and they were always eager and willing to engage into discussions at any given time.

Activities with the school children

The school children would come after school to attend sessions for three days a week and two hours a day, from 2pm to 4pm. If necessary, I pre-arranged with the parents when we would assemble on a Saturday morning. From the first week of our afternoon meetings the

children took charge of most of the afternoon arrangements. The children would re-arrange the desks and chairs in the classroom in the way they wanted to sit as soon as they entered from their formal day of school. The children felt that if they arranged the small desks and chairs in a manner other than the normal rows in which they sat at school, they felt a little more relaxed. Then, they would collect water to wash their hands and I would prepare a lunch that would consist of *vetkoek*, a drink and various fruit. They would organise themselves and cut up some of the fruit and see to the distribution of the food available to each individual. They would also take out the boxes in which their individual activities were stored.

Figure 4: *Vetkoek*

The children would first take a break, going outside to play, and eventually we would start our afternoon discussions. I should mention that at various stages during these sessions, the conversations sometimes became quite noisy. Those who opted not to join in any of the participatory methods went outside to play and would usually eventually come back and complete a task or, on some days, just enjoy doing nothing and continue to play, kicking a ball or running around playing traditional games.

Activities and non-school attending children

I would normally meet the four children that did not attend school in the mornings at the individual homesteads where they lived and help with some of their daily duties. With the two boys, I would normally help to gather and cart wood. The wood would be chopped and sold in the neighbourhood during the day, the proceeds from which served as an income for their individual households (see Chapter Eight for detailed discussions). With the two girls, I would normally go to the local *cuca* shop to buy some items they needed and then help with some of their caring activities. Discussions would take place during these times and I would normally pack baskets with fruit and food for them to eat during our discussions. In some of the participatory activities, such as the diaries, I chose not to involve them. I did not want to offend the children because all of them had informed me that they never attended school and it was likely that they were not comfortably literate. As hard and challenging as it was to execute some of the participatory methods, the children enjoyed the activities because it was different from their normal routine and they were always willing to accommodate me and looked forward to our meeting times.

Participatory data collection methods

The choice of research methods for children is important in order to respect the children's rights to participate (O'Kane, 2008). Children are more likely to participate freely and openly if they feel respected and safe in relation to the balance of power, voice and representation between the adult researcher and the child informant (Gollop, 2000; Christensen, 2004). It was important to attempt to reduce the power imbalance between the researcher and the children involved in the study and therefore I took the time to build relationships with the children, their peers, the parents, the caregivers and many others, all of whom contributed further to the study. With this intention, a phased approach was used in order to nurture stable and long lasting relationships with my main research participants, the children (Harcourt, 2011). I put considerable effort into establishing relationships with the school children through participant-observation, walking home with them, transporting them, teaching them, and eventually gaining their assent to participate in my research. My presence living in the village, walking, talking, and interacting with the children in their community contributed to developing trust relationships. Once I had arranged home visits,

I tried to do the same with the children's guardians and parents: sometimes giving them rides to nearby towns and having casual discussions with them.

Together with the rich narrative of ethnographies of the 26 children in my study, which forms the majority of my thesis discussion, data was complemented by various additional participatory data collection methods, to further enhance the contribution of the children in the study. In recognising both the biological and structural conditions which shape children's lives, there is a need to develop communal strategies which engage children, build upon their own abilities and capabilities, and allow their own agendas to take precedence. The use of participatory activities does precisely this. In addition, Allison James (1999, 245) argued that:

> It behoves us then to make use of these different abilities rather than asking children to participate unpractised in interviews or unasked submit them to our observational and surveilling gaze. Talking with children about the meanings they themselves attribute to their paintings or asking them to write a story … allows children to engage more productively with our research questions using the talents which they, as children, possess.

These experts refer to the child as an individual, capable of reacting and making sense of their world and therefore worthy of being research participants in their own right and contributing to issues that affect their daily lives (Evers et al., 2011). Furthermore, these participatory methods were mainly utilised to ensure the children in the study had fun and could learn something new or different from their daily lives at school or at home. Children could relate through these activities to reflect on their daily health and illness challenges. For participants at the school, I always planned at least two activities to run concurrently. This allowed children an alternative if they did not wish to work on the actual planned activity for the day, or decided at some point they needed some time out of the activity.[30] For the non-school attending children, this was rather difficult because all the activities had

[30] I refer to the work of Abney (2014) where she talks about the "ideal participant" and the idea that non-participation must not be viewed negatively.

to be planned around their daily routine at home, however they were eager to make it work.

In addition to interviewing, five other participatory data collection methods were used, each of which was intended to approach concepts of health and illness from a different perspective. The first of these was **drawing**, which has been used in many studies involving children. As noted by Hinton (2000), working amongst Bhutanese refugee children in Nepal, drawing helped to create an understanding of children's perceptions of health and healthcare. As a familiar pastime, drawing takes away some of the pressure a child might have when being interviewed and the obligation of having to have an answer to questions being posed and the uncertainty of giving a response or the fear of not having the correct answer to a question (Abney, 2014). Children therefore have more time to relax, construct and think when the verbal pressure of discussion is taken away, which creates allows for creative responses to issues that might have otherwise been difficult to express.

In this method, two sets of pictures were drawn with coloured pencils. One set was about being healthy, and how the children felt when they were healthy. The second set of drawings was about the last time they were sick and how they had felt. Other drawings included their homestead, family, friends and other things of importance to them. Drawings were made about those who had helped them when they were sick and what measures were taken to help them recover. Art was not offered at the local school so drawing was not familiar to these children and at times they did not enjoy the exercise, some asking each other, "Must we do this?" However, there were children that had some speech problems and those that were not as verbally articulate as the rest enjoyed the drawing more than the others. At a later stage the children had individual sessions to discuss the drawings.[31]

[31] I would leave the room to give children space to think and sometimes join the children outside that kicked a ball or played traditional games. This would give the children the freedom not to feel pressured by seeing me around. I also kept the asking of questions to a minimum to let children see the way through their drawing themselves.

Figure 5: Drawings

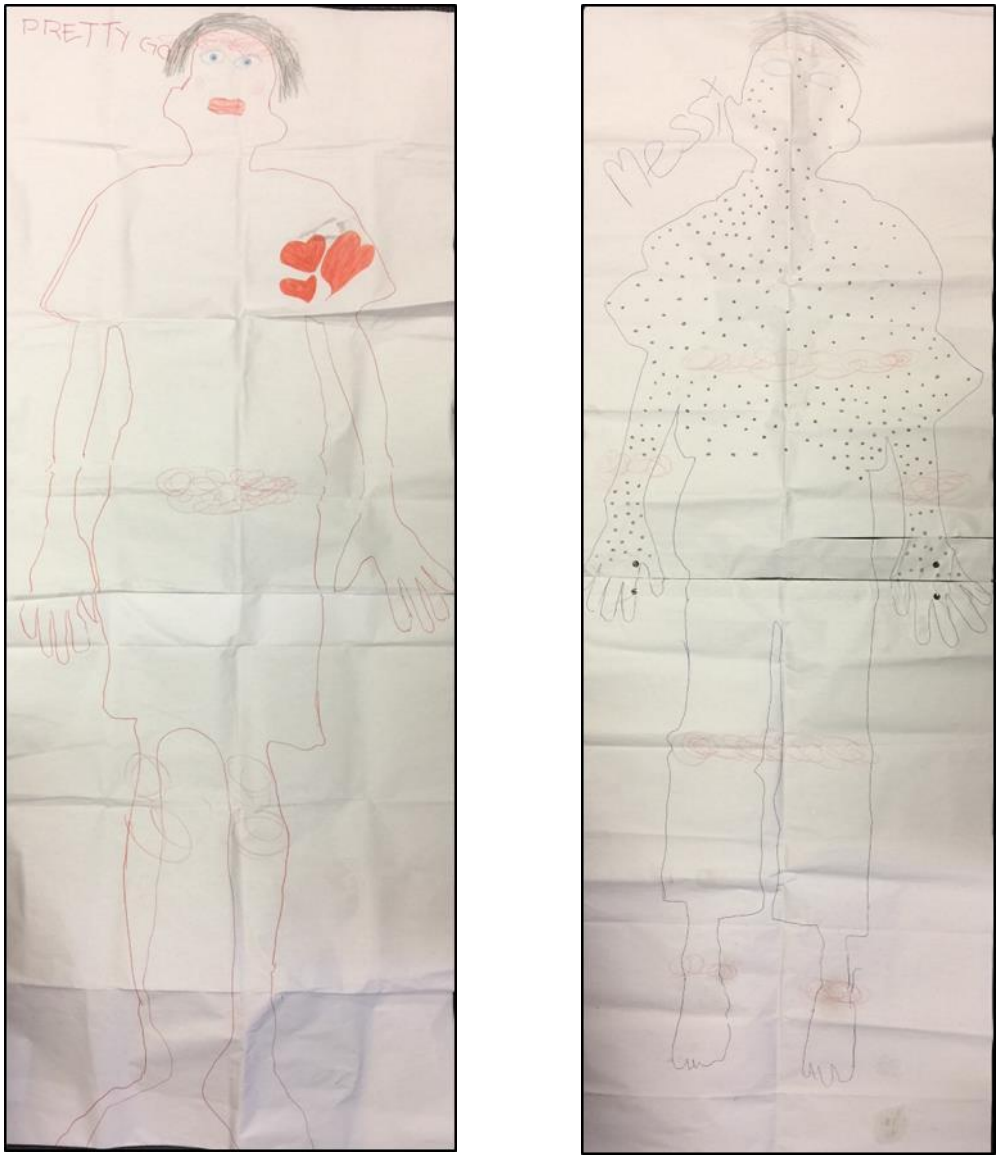

Figure 6: Body mapping

The second method, **body mapping**, consisted of drawing the physical body, and this particular method was intended to bring out the children's creative spirit and the richness of the visual illustrations showing how the children see themselves (Mitchell, 2006). Gillian Rose (2012), in her work on visual methodologies, states that using a critical visual methodology enables the participant to draw an analysis of not only what they have portrayed in regard to the subject matter, but also to reflect on their daily world and how it affects them. The exercise comprised one child mapping an outline around another's body as they lay on the floor and then changing places. The children's reactions to what they saw after their partner had made the tracing of their outer body was particularly closely observed. During the individual sessions, the inside of their body was drawn and the results followed by in-depth discussion.[32]

The third participatory method used was **photovoice**, during which the children were shown how to work with a camera and given the opportunity to take photos around their homesteads and other places of interest to them. This method was used by Rachel Baker, during her fieldwork with street children in Nepal, inspiring active participation in the study and helping her to gain insight into the lives of the children (Baker, Panter-Brick & Todd, 1996). Similarly, the study of Morten Skovdal and colleagues (2009), on care-giving children's experiences in Kenya, suggested that photovoice was a useful tool, especially in marginalised communities, in that it helped give expression to the children's local environment, bringing out perspectives on behalf of their communities that might not otherwise have been possible. Photovoice therefore becomes a tool whereby children can articulate concepts about their world and the environment they are surrounded by, further giving them a voice (Bartos, 2012, 158). This particular method enabled me to spend time with participants at their homesteads where all the pictures were taken. Therefore, I could observe relevant aspects of their daily social and cultural lives, which they expressed in our numerous discussions and through the other participatory methods. The pictures they took described what was important to the young participants within their own environments and

[32] The girls were shy the first day and did not wanted to participate because they felt awkward lying in front of the boys in their school skirts. It was then agreed that they would bring some pants to cover their legs. After this decision, this exercise was fully enjoyed by the children and rated as one of their favourites.

could be used as topics for discussion, giving the children space to talk freely and openly during individual discussions.

Another advantage of photovoice was that it brought out topics for discussion that the children would never have otherwise spoken about. In relation to the work of Darrin Hodgetts, Kerry Chamberlain and Alan Radley (2007), photos "never taken during photo-production projects" must be regarded as equally important as those that were taken. The authors argue that that photos not taken but spoken about provide insight into the 'life worlds' of the participants. This observation was also true for my participants in this study and examples will be discussed in Chapter Six.

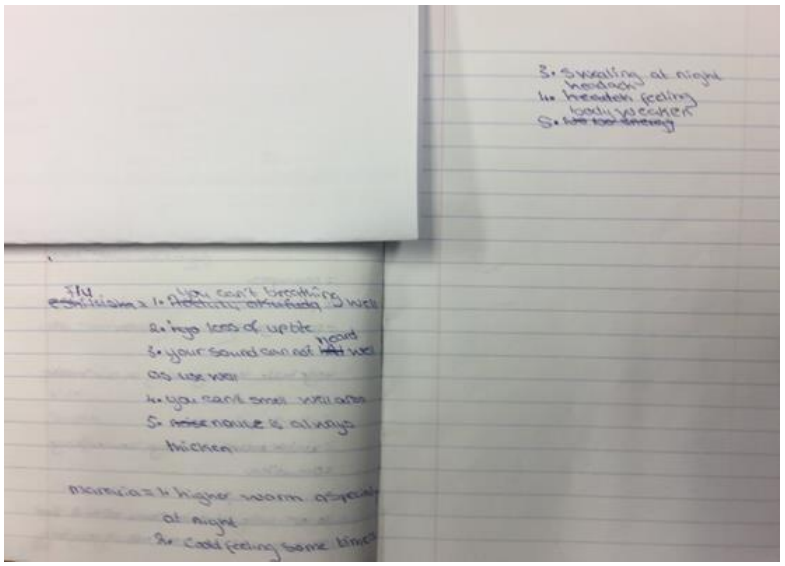

Figure 7: Free listing

Free listing is a cognitive anthropological method, designed to elicit subconscious information from the participant (Quinlan, 2005; Kotey, 2012). It involves participants being asked to list key words within a set time. For example, the children were asked to create a list of sicknesses they had experienced or were familiar with and listed illnesses like flu, malaria, measles and chickenpox. Following the exercise, individual conversations took place with each child to allow more detailed discussion of the words listed.

The fifth method, and also the most time-intensive, was the keeping of **health diaries**. Discussion of what a health diary might entail was held with the children, explaining that they might record such details as what they ate when they when healthy (what their diets consisted of), and how they kept themselves healthy or where they got their health information. Alternatively, details of sickness might be recorded, for example how many days they spent in bed, at home or in hospital, who looked after them, what medicines they used, and how they became healthy again. Individual discussion followed to highlight certain aspects that had been written and displayed in the health diaries. Writing in the health diaries, although confidential, was limited to the group sessions and before the children left the diaries were handed to me for safe keeping and locked away. However, at the request of the children, a second diary – an open diary – was instituted which served as a rough notebook in which they could keep notes without prescription and these they took home to have conversations with their guardians and siblings. Introduction of the open diary was a successful initiative as the children in the study returned, telling me it was the first time they had conversations with most of their guardians about health and illness, and some of the guardians in turn who I met along the road informed me they were happier about the classes as through the open diary they gained some insight about what we were discussed.

Figure 8: Closed and open diaries and the files of participants

In additional to the participatory methods, various ball games and traditional games were played outside the meeting room in groups to help assist with team building and to occupy those that did not want to engage in the classroom activity. This phenomenon of the young participants deciding for themselves when and how they wanted to participate during the

study is something not often mentioned in studies, so it is necessary to include. Abney (2014, 41) in talking about the "ideal participant" and the "reconceptualization of the ethnographic kid" in her study with paediatric tuberculosis patients explained that her participants wanted to participate on their "own terms and in their own way." She described this need with reference to the work of João de Pina-Cabral (2013), using the phrase "methodological mutuality." Although my co-researchers would eventually return and start the planned activity, the games were a way for them to tell me without offending me that they would do the activity when they felt like it and thereby maintain some control over the research process. As researchers we need to accept this notion fully. Following on from the work of Christensen (2004, 170), Alison Clark and Peter Moss (2011) state that when doing research with children, they need to be treated respectfully and with care, arguing, "It is not only of seeing the world from children's perspectives but of acknowledging their rights to express their point of view or to remain silent. We are keen that participatory approach to listening is respectful of children's views and also of their silences." I would argue that this need to be treated respectfully is particularly the case in the African context, where children are still marginalised in research, and allowing the children who participated in the study to go outside to kick a ball instead of immediately starting with the activity of the day was one way of being "respectful of their silences".

The children often preferred **individual discussions** and, as a topic was introduced in class, they would then apply it in either of their health diaries (open or closed) where most of their topic discussions were recorded. The children preferred the individual discussions because they felt they could speak more freely and no one was watching or potentially laughing at them. They indicated that they felt relaxed and not rushed and could take their time to look at all the work they had completed over several months. Once the results of each of the participatory activities was laid out in the more private room away from the normal class set-up, the children would start to talk arbitrarily, picking up whichever activity they felt most comfortable with or enjoyed the most to start the discussion.

In sum, my research methods were child-centred in their design, and sought to be responsive to the needs and desires of the children. This approach was strongly influenced by my earlier experiences of seeing children in Namibia with no voice, and, in the contexts

of health and illness, a lack of voice that harmed their health and sense of wellbeing. In taking this approach, I developed real and complex relationships with the children that were rewarding and at times difficult, heart breaking and complicated, and within which I had to learn to tread carefully, as will be detailed in the chapters that follow.

CHAPTER FOUR

Biomedical citizens in the making: school curricula, clinics, dirt and lived experience

> In bringing the biological into relation with sociality, the dividing line between the two is blurred. Space, often conceptualized as external to a 'bounded' individual, traduces both internal and external landscapes where experiences of the body's disintegration interweaves with social relations (Henderson, 2004, 43).

Introduction

In this chapter I seek to explore how children come to act as biomedical citizens in rural Namibia. As João Biehl (2004) argues, biomedical citizens navigate forms of social inclusion and exclusion through the biomedical domain. By examining the role of children as agents of health in family settings, schools, clinics and communities, I seek to reveal how children are central to the means by which biomedicine gets enacted on a daily basis, and how it gains legitimacy as a social good and necessity in these communities. I also reveal how children creatively interpret and transform biomedical knowledge as individuals, with peers, in families and in the wider community. I will show how children act as brokers, mediators and translators between local systems of healing and biomedicine, between family members with less or more biomedical knowledge, and between different social spheres, such as the homestead, the school, the clinic and the state. Children's agency emerged as children both exerted their desires for health, and struggled with the social constraints they faced. At the same time, their desires and actions emerged out a sense of self that was intimately tied to their responsibilities to others and their roles within family spheres.

Schools at the centre of biomedical citizenship

In working towards nation building after independence, the Namibian Ministry of Education embarked on various changes in the health curricula of schools (Kasanda et al., 2012). They aimed to ensure "rural hygiene" improved, but the process raised many challenges regarding how such measures could be funded, implemented and sustained. Anthropological studies of the state have shown how state agents implement and make

visible state programmes and services, which ultimately act as a means of political and social control (Coe, 2005; Cohen, 1984). Through processes such as teaching farmers new technologies, introducing new drainage systems, setting up health facilities, establishing town councils and land surveying, states seek to consolidate their power through new measures to protect and enhance life (Foucault, 1975). Many of the health interventions that anthropologists have examined, however, do not make reference to schools and primary level health education. This is despite scholars noting that schooling is commonly a key tool in a government's vision of social order and control (e.g. Foucault, 1994). Schools function as a central instrument in citizenship making, in shaping children's behaviours and ideas, and in their ongoing relationship to their state, their expectations of rights and entitlements, and their sense of duty and responsibility for the wellbeing of the nation.
Studies shows that the improvement of mass education in Namibia was a particularly strong focus after Namibia's independence, when the government sought to rectify the inequalities, health disparities, and uneven levels of opportunity that emerged during the apartheid era (Kasanda et al., 2012; Katjavivi, 1988).

In Namibia, local teachers are key actors through whom knowledge is dispersed and nationhood is built. They are supported by prescribed text books and ongoing efforts to revise curricula from central government. Michel Foucault's (1994) idea on governmentality, applies and can be critiqued here. As I will show throughout this chapter, schools seek to empower children through specific health discourses. At the same time, such governmental techniques are limited when resources are scarce and government policies fail to reach the classroom. The gap between what the Namibian government desires to promote, and what they can uphold and sustain as a developing country, in terms of providing clean water supplies, electricity, roads, and infrastructure, is often a stark contrast. As one of my young participants noted, health education is often "just a distant dream from a magazine." The gap between what children are taught and see in their textbooks and their daily experiences, especially in terms of rural hygiene, leaves them to develop their own strategies to stay healthy. These strategies sometimes contradict the government's development and biomedical policies. Children learn to adapt where limited resources exist, at the same time that they learn to talk 'biomedically' when around teachers who promote biomedical curricula, and when they are tested in school assessments and exams. However,

as observed during my fieldwork, children devise alternative strategies that can appear to contradict biomedical advice in order to enact care for themselves and within their families beyond the classroom.

I take a similar approach to that of Maisie Dagapioso (2014), in her study on Filipino street children. She argues that the street children's health is not just a medical concern but is continuously influenced by political, gender, economic and cultural factors, and thus a holistic approach is essential in understanding children's health behaviours. She further demonstrates that children are capable of making complex decisions regarding their health, and are not simply receptors of biological citizenship, but actively contribute to bio-citizenship models and practices. This issue became real to me early in my fieldwork. One evening, after the start of the afternoon class with the 22 school children, I walked towards my pick-up truck where it was parked on the school premises. I became curious when a few boys jumped up from behind the truck. It seemed to me that they had just been hiding, but on closer inspection I realised that they had been defecating on the ground, no more than a few metres away from the school toilets. These and other occurrences marked the start of numerous discussions with the children about health as an object in the school curriculum versus health, care and the daily reality in the children's school and village life. These ethnographic moments revealed how biomedical citizenship, while a global phenomenon within a state-based world, is enacted in specifically local ways that relate in this case to the pressing concerns of rural Namibian lifeworlds.

Building biological citizens in school

Biological citizenship as a concept seeks a better understanding of how medicine, healthcare and biomedicine mediates the relationship between governments and citizens, and the expectations each has on how to maintain the health of the nation (Rose, 2007; Petryna, 2002). Ethnographically, attending to biomedical citizenship highlights people's agency, how they navigate inequalities that impact upon their bodies, and how people are excluded or included in biomedical discourse at local and international levels (Lock & Nguyen, 2010).[33]

[33] See the work of Decoteau (2013), Biehl (2004) and Petryna (2002) who collectively look at biomedical citizenship in terms of agency, inequality and the voicelessness of sufferers and advocate for better health care, access and compensation.

Nikolas Rose (2007, 131) argued that biological citizenship rises in in different ways in parallel with the emergence of civil rights, "political citizenship" in the 19th century, and "social citizenship" in the 20th century.[34] Against the background of these political developments, Rose argued that we have witnessed the rise of "citizenship projects" where the state and citizens negotiate what an ideal citizen is, how they can participate politically, and how they are to be educated in their civic duties, rights and responsibilities.

Ruth Fitzgerald (2008) argues that biological citizenship is far more than just the state or government providing basic healthcare to end patient suffering, and often involves strong patient advocacy networks, which seek to proactively shape government priorities and policies. Fitzgerald's (2008) study with the parents of children with rare disorders shows that governments seek to work through parent advocates, with little emphasis on children's voices. In seeking to address the imbalance that Fitzgerald notes, and in contrast to much of the literature on biological citizenship that focuses upon adults and often upon those directly engaging with government health organisations, my study examines biological citizenship from the perspective of children themselves, and at a distance from the heart of the state and its agents, focusing instead on daily rituals, strategies and practices. While my focus is on the children's perspectives, it is also important to explore the motivations, drivers and goals of the Namibian government and educational system. Since independence, the Namibian Ministry of Education's desire to produce 'better' and 'healthier' citizens is linked in part to external global pressures to modernize and adhere to the targets of the World Health Organization and other international development bodies. Therefore, my young participants' own voices and cultural narratives at a local level were simultaneously locally specific experiences and "transnationalised" experiences (Fitzgerald, 2008) linked to wider global processes.

Governmental and school approaches

The Namibian government has worked hard since independence to ensure better health services in established communities and urban areas, especially in areas where there had been no such services prior to independence. However, according to Diana Gibson and

[34] "Political citizenship" here refers to rights of political participation, while "social citizenship" refers to access to basic social services such as health, education and welfare (Rose, 2007).

Estelle Oosthuysen (2012, 86), who worked amongst the San in the north-eastern part of Namibia, biomedicine cannot be regarded nationally as a "unitary system". This is particularly evident in my own research in rural and remote settlements where government investment in sanitation and hygiene measures remains low. The *Namibia Demographic and Health Survey 2013* (MoHSS & ICF International, 2014) results indicated that 46 per cent of the population, particularly in the rural areas, are without basic sanitation and still practice defecation in open fields and surrounding areas. The Ohangwena Region, where my study took place, is listed by the Namibian Red Cross Society as one of the five most severely affected areas where high rates of open defecation still take place. Therefore, a recent initiative (introduced in July 2015 and continuing through 2016) called WASH (Water, Sanitation and Hygiene) was instigated through UNICEF Namibia and marked a renewed effort specifically geared to supporting hygiene and sanitation amongst schools, traditional leaders and malnourished children in the Ohangwena Region. This initiative builds upon previous training provided by the government to the region, which has had little long term effect: the Namibia Approach to Total Sanitation (NATS), which started in 2013. When my fieldwork started in 2013, the village was not included in the study, despite being formally designated by the government as being included as part of the programme. During my fieldwork, toilets at the local primary school were not serviced as they should have been, leading to children defecating outside the toilet building, as described above. The reach of the state and governmental health projects in developing nations often means that biological citizenship can be as much the result of processes of neglect as of governmental intervention. The uneven dimensions of biopower, as Foucault (1975) argued, involve processes that both seek to enhance and sustain certain lives, or to neglect certain populations to the point of death.

The school curriculum teaches hygiene, with a focus on hand washing and correct defecation. The Namibian teaching system is characterized by didactic learning in which communication largely flows one way from teacher to student, making it a top-down teaching approach (Boer, 2012). Although huge reforms have taken place in Namibian teaching systems since independence, in terms of improved teacher training, the process of introducing a new and comprehensive curriculum is still in process, and with limited national resources, the transition from the previous colonial system toward a fully

developed Namibian education system is no easy task (Amukugo, 1993, Dahlstrom et al., 1999; Wilmot & Nyambe, 2015).

During my time at the local school they lacked a health science teacher. In my role as a volunteer, I took on this position for six weeks before I embarked on group work with my young participants. While acting as a volunteer teacher I noticed that the children would stand up when a teacher entered the classroom. The first time this happened it surprised me, when a teacher from next door appeared in order to have a quick word with me. Upon seeing her, the children jumped up from their desks and remained standing until the teacher left the class again. Like soldiers standing on guard, they would shout, "Good morning teacher," in unison. In some cases, teachers would take their time, seemingly totally unaware that the children were left standing until the teacher instructed them to take their seats. The children told me that the teachers just did not care about health education because there was no time for those discussions, and the teacher's main aim was to get through the core curriculum in order for the children to be tested and prepared for examinations. With the strongly authoritarian teaching model, children felt they could not voice any health concerns with teachers.

To illustrate some of the topics covered during my six weeks of voluntary teaching, I brought old magazines to the classroom and the children would pair up to compile posters according to the topics we covered. We would then have informal discussions around these. The children enjoyed these exercises immensely and it would spark highly engaged discussions.
It was after one of the sessions that a girl, Joyce, while helping me to tidy the classroom with a few friends, thanked me, "*Meme*, it is so nice that you are letting us have some discussions and also browse through some magazines and put up posters related to what we have discussed." Another girl, Grace, piped up, "I think teachers don't care about health because they hardly talk to us properly about it or anything, and you dare not ask them or question them about anything extra." Joyce looked around to see if any teachers were near, adding, "I think they do not care and only want us to do the tests and examinations to get done with it all." I asked them what they wanted the teachers to discuss with them. Joyce again looked around and this time closed the classroom door. "There are just things we'd like to share, and make our own experiences known. We help at home with so many

things and that must count for something, and here at school many things in the health class could be improved, which we could help with." Grace added,

> We could start our own garden at school because I love gardening and have my own at home. A garden at school could help give better food to our feeding scheme at school. I also think we, as the girls, could organize the feeding scheme better and give a helping hand as we do at home … *Meme*, it's actually simple what we want, just more discussions in class would help and not always listening to the teacher's voice and explanations, only hurrying as quickly as possible through the textbook and making us write tests and prepare for examinations.

Despite the problems noted by the children, their very expression of wanting things to be better indicates the emergence of biological citizens in the making. They valued health class as a vital and useful aspect of their education, and they saw strong links between what they learnt in the classroom and their daily lives at home. Their desire to be able to express themselves, to have their voices heard, and to be recognised as having valuable knowledge and being active agents in the realm of health and wellbeing was also evident in these complaints. As young citizens of Namibia, they were already aware of their educational rights vis-à-vis the state. The language of such 'rights' has been promoted by the Namibian state since independence, when the government promised that, after the colonial era, Namibians could expect a range of improvements and services, from education to housing to health. Despite the problems in enacting such promises, Namibians have come to understand their relationship with the post-independence state as built upon these fundamental promises. These understandings have been socialised within families, who still remember when such promises were made by the first President, Sam Nujoma, and children grow up, even within poor families and within poor regions, with expectations of such fundamental rights.

Children's perspectives on health education

I conducted a range of exercises with the children to understand their own perspectives of health, hygiene and wellbeing. I was curious as to why most of them did not use the toilets built on the premises or wash their hands at the tap, when this was a clear health message

in their daily school curriculum. During their drawing sessions and in several discussions, children detailed how they used the local bush or nearby fields to defecate. A drawing by Messy illustrated this. Bringing me his drawing, he said, "*Meme*, do you like this drawing? This is the reality of what I do every day at home, but also sometimes at school even when the toilets are there." He kept his hands in front of his mouth, looking embarrassed at showing me and then started to laugh. I was curious to know why. Messy explained,

> I use the bush at home, no problem for me, but at school if the toilets become too full [when not serviced by the local governmental authorities], I have no choice and sometimes I think it's safer to find a place around the school outside the toilets to use, because my sister gets sick when she uses the toilets when they are full, and that's why I am worried it will happen to me. I also think the really full toilets and the stink it leaves on you is what makes learners at school sick.

Messy continued, further explaining, "Using the bush at home we never get sick but using the full toilets at school makes learners sick." I was curious to know why he thought the bush at home was safer. Messy told me that there was nothing else other than the bush to use, and the area at home was big so that you were not confined to one space, and people made use of the sand and dug holes to cover defecation, which as he referred to as "nature takes [it] away." As he pulled his Nature, Science and Health Education book out of the plastic bag in which his schoolbooks were carried, he said, "*Meme*, let me show you how the people [those who design and write the curriculum] think we must learn things, and things which are only in books and not around the village." He quickly turned the pages of the book to a section entitled "The importance of clean water for life." Messy highlighted a section where children were advised how to keep their bodies clean and healthy. He pointed out a few of the lines and started to laugh and explained, "*Meme*, we are the children that carry water and it is so difficult just to have enough water for cooking so what about washing?" He pointed to the colour pages illustrated in his textbook. "Now this book is telling us to wash every day, keep clean clothes and wash our hair, when we do not have running water at our houses." I asked Messy what he thought a solution would be. He first looked up into the air and boldly replied, "If I am the President one day, I will give people running water coming from these taps that they show in the book, and also not the pit

latrine toilets [but flush toilets]." He showed me another picture from his textbook of children washing their hands from a tap, and another picture of a flush toilet. "Once children have better taps and toilets they would learn better and not be sick. For now, it's better for me and my other siblings to continue to use the bush in order not to get sick because it's for us the safest." I asked him whether, since he felt the bush was the safest place to defecate, the toilets at the school needed to be removed. He was quick to answer, "No, no, *Meme*, if they [the local government authorities in charge of servicing] could come around more often and empty the buckets it would be safer and good for us because it is uncomfortable and difficult to hide [while defecating outdoors at school] because of the space, but at home the space is bigger."[35]

My conversation with Messy reflects how the national school curriculum assumes an infrastructural reality not yet realised in rural Namibia. That the children do not act as the health books dictate does not indicate they lack health knowledge. Rather, children have incorporated the principles of hygiene, bugs and sickness that they have learned in school into their daily practices. They thus seek to avoid the health risks of faeces, which make the school toilets a health risk, rather than a health solution. They acknowledge the relevance and importance of the biomedical health model, and use this model to imagine a healthier environment at school. Their so-called unhygienic behaviour reflects a health strategy to cope with and adapt to an unhealthy environment in which infrastructural failure turns hygiene objects (the school latrine) into health risks. These behaviours also reflect the limited and compromised daily priorities they must make to stay well, such as carrying water for cooking and drinking, instead of for washing themselves.

[35] According to the *Namibia Demographic & Health Survey 2013* (MoHSS & ICF International, 2014), the WHO and UNICEF classified a household as having an "improved toilet" if only the members of that specific household used the toilet facility, the toilet was not shared by any other households and there was no human contact with the waste. Therefore, these improved toilets must adhere to a certain standard which enables the household to have pouring flushability or flushing toilets into a sewerage pipe facility, septic tank, pit latrine, ventilated improved pit (VIP) pit or latrine toilet with a concrete slab. Therefore, by these standards of waste disposal and sanitation only 34 per cent of Namibians utilise an improved toilet system that they do not share with any other households, while an additional 15 per cent of the households use an improved toilet system but do share. The same report indicated that in the urban areas of Namibia 49 per cent of households has an improved toilet system that is not shared, as compared to 17 per cent in the rural areas. More than 51 per cent therefore do not have access to improved toilet facilities, while 46 per cent still remain without any toilet facilities. These statistics are a slight improvement to the 49 per cent that did not have access to improved toilet facilities as recorded in the 2006-2007 *Namibian Demographic & Health Survey* (MoHSS & Macro International Inc., 2008).

This situation is an example of what Claire Decoteau (2013, 21) describes as "a form of exclusionary inclusion." She details the South African government's providing of antiretroviral medication to people living in poor conditions, while not providing adequate housing facilities and other services to ensure their health and wellbeing, and to guarantee the efficacy of the drugs. The glossy coloured textbooks provided by the Namibian government, that aspire to make children better biomedical citizens through health education, jar with the reality of what the school children experience on a daily basis and the resources provided to them by the state. But the textbook does provide the children with aspirations for what their school should be like, and what, as citizens, they are entitled to. Messy, Beauty and the other children thus believed that if service delivery was adhered to at school, their lives would be easier and healthier. This reveals that the textbook both demonstrates to children their marginalisation vis-à-vis the state, but also empowers them to imagine a better situation that the state should provide to them as a right.[36]

My young participants criticised the teachers for both knowing the reality of their lives, and still teaching practices that were unrealistic for the children to achieve. The children, for example, talked about using sand to rub their hands to clean them and felt it helped them to kill any germs. Elas explained, in our after-school group discussion, "The teachers know because we come from the same area. Where do they expect us to get water from at night when it has all been used for cooking, drinking and washing our hands before eating? They know we all use sand, but they tell us to wash our hands at night after using the toilet. They are crazy." He hid his mouth behind his hands and added, without making any eye contact, "I think sometimes they come from another planet." Beauty added, laughing, "I think everything works together. Your hands need to be clean at all times. Sometimes after being in the bush there is no water, but sand helps and the leaves or anything from God." I asked Beauty what she meant by anything from God. "The leaves from the bushes, the bird feathers, anything from the ground that helps."

[36] This compares with findings from Kenya from a study of Luo children's thoughts about worms and illness, which found that the combination of children moving between the traditional (at home in the village) and modern experiences (at school and the curriculum) were important in shaping their thinking about their bodies and their ideas of health and illness, in terms of becoming future citizens (Geissler, 1998).

The children's critiques revealed the disjuncture between governmental authorities who design school curricula and the daily life of children in rural northern Namibia. As Edward Evans-Pritchard (1976, 31-32) argues, knowledge can come in two forms. For my young participants, health knowledge was "actualized" within their roles as care providers in their village. This was in contrast to the school, where health sciences and biomedical citizenship provided knowledge as "doctrines" of correct behaviour. The children reveal that biological knowledge is never removed from the wider social context in which it is enacted through daily practice. In a similar critical discussion within the discipline of anthropology, Margaret Lock (2013) warns of the consequences of leaving the "body" to biologists and the biological sciences, "black boxing" it there, and in the process making it harder to identify concerns and inequalities surrounding political and social transformations that are emergent through biological changes and "local biologies".

These issues that the children face are exacerbated by the difficulty of obtaining water at certain times of the year, particularly as the community waits for the November and December seasonal rain to come. The boreholes dry up and the water gets contaminated. The children further mentioned that they could obtain water purification sachets from the local clinic, but the clinic was sometimes too far or did not have any in stock. In such a compromised situation, my young participants were pragmatic in devising solutions in reaction to a scarcity of water. Beauty said,

> At school the teachers teach us to wash our hands after using the toilets, but the toilets are so far from the taps and are sometimes locked or without water. In our culture you cannot eat if you do not wash your hands. [It's customary for the Aaumbo people] … that a bucket goes around to wash your hands. I think it's a better solution than the taps at school that have so many problems. They could just put a bucket of water outside the toilets and we could wash our hands.

According to María Del Carmen Davó-Blanes and Daniel La Parra (2012), who explored how children take responsibility for their own health in Spain, children's active involvement and decision making in health education at schools had wide reaching positive effects on their

daily lives and their social surroundings. This finding is echoed in studies by Akello and colleagues (2007) in Uganda amongst primary school children, which examined children's perceptions of common diseases and medicines. This study showed that children had appropriate and relevant knowledge important to their own survival that could shape health policies. Working with my young participants, I became aware of their immense eagerness to talk about health, illness and care. Most of these children took care of their siblings, grandparents and bedridden family members and became active health agents for themselves and those with whom they lived. They wanted the teachers at the school to assist them to further enhance their coping skills and wellbeing in their busy and sometimes arduous lives. In one of the group activities in the health classes that I volunteered to teach, the students spoke about their frustration regarding the lack of physical education, and the lack of sports facilities, which they thought could help to improve their general health. We were discussing the human body and breathing, which covered various aspects of disease, germs and "being healthy". The book's illustrations made use of being involved in athletics as an example of healthy living, which led to discussions about how they felt when they were healthy or sick.[37]

Afterwards, Lady entered the teacher's house where individual discussions with me took place. She was carrying a ball. "I like playing netball, it keeps me healthy and fit," she explained. "*Meme*, what do you see when you look out of the window?" As I was about to answer, Lady said, "Nothing, just dusty fields." Lady further explained that,

> If I do netball activities I feel happy, fresh to do my school work, and do not get sick that much as compared to when I do no exercise. There is no support at the school but me and a few friends try to play on our own to keep fit and we have our own games where we run around and try to catch each other, and in our own way that keeps us going, and that is our "athletics". Our ball got stolen but the new balls you brought to the school will help us to continue to play netball,

[37] Zealand (2008) in discussion of his research in 'Physical activity and self-esteem: A Namibian youth perspective' explains that young people that are underprivileged have a tendency to feel inferior and ashamed and may have suicidal thoughts. They may express their behaviours and anxiety through becoming involved in various criminal activities. Zealand advocates for physical education, not just as a means of addressing ill health, but also to improve self-esteem and to be used as a valuable tool to help to cope within school and daily social environments.

> even if it is on our own. When we ask the teacher to help us to practice, they simply refuse and tell us they do not have time. I feel if I am healthy I can also help better at home where help is always needed to carry water, pick up wood or look after my siblings.

When asked about being sick, she explained further, “I feel completely miserable and helpless, and do not want to eat and in any case there is nobody to look after me because everybody is busy, and if I am healthy all is well in the house, but if I am sick things go wrong because my brothers and sisters depend on me.”

In a similar vein, Rooney, a keen soccer player, described being sick thus:

> I feel miserable, awful, helpless, hate being sick, and being healthy is the best because I can do more at school and also at home. I feel doing sports at school will help to keep me fit and strong. My family depends on me herding the cattle after school and they do not have money to pay anybody else, therefore, being healthy is important to me not just for school but my family.

Expressing these desires to stay fit in order to be healthy and perform their daily tasks revealed a less visible childhood aspiration. Their often physically demanding daily chores, in addition to walking to school every day, already gave the children a high level of fitness. The children however used the accepted language of health and fitness, and the socially sanctioned goal of looking after their families, in order to articulate a quite different personal goal: to have more time and resources for child-focused games and fun activities at school. This doublespeak can be seen in a conversation with Penny, who said that being able to play sports at school did not only keep her healthy but also gave her something different to do instead of just sitting in class during the physical education period “doing nothing”. She explained that,

> Being healthy is everything to me. I feel like I’m worthless, unable to move, and very helpless when I am sick. When I am healthy I am able to do more than just my schoolwork and help better at home where almost all of my strength is needed to carry water, help with the washing, look after my grandmother, brothers and sisters, cook, and do many more things I have to do.

All of the 22 school children described the illustrations in the prescribed textbooks of sports fields, facilities and equipment as “useless” and “irrelevant” because they did not correspond to the opportunities and environment that the village school provided.

The children had their own reasons for wanting to do exercise, which related to their wider social lives beyond school. Upon my arrival in the village in early April 2013, it was the harvesting season. I was struck by how the children would help the elderly to carry and clear the *mahangu* fields, carrying head-loads of harvest until sunset. Living with a local family, I shared my room with two children, who would rise at five o’clock in the morning and sometimes even earlier to collect wood and water for the morning meal. They would care for smaller siblings, elderly and sick family members before they left for school. In the afternoon, upon returning from school, they would engage in the same activities again, as well as pounding *mahangu* for an hour. The children were very proud of their ability to perform their daily tasks and would often laugh at me when I did not have the stamina to pound *mahangu* in the way that they did. The children would end their day doing washing, herding and cooking the evening meal, as well as doing their schoolwork, before they eventually went to bed when it got dark, usually before seven p.m.

Figure 9: Rosa pounding *mahangu*

Saying they wanted more time for sports and to play also involved asserting that they could do something with their bodies that they chose. They felt that exercise was enjoyable and relaxing, and helped them to cope with the demands of their daily tasks by giving them time

off, and doing something "fun" and "different" in contrast to the repetitive, demanding nature of their chores. Health, therefore, became a language through which they could assert that they were still children, and that a healthy childhood required leisure, play and fun.

The lack of meaningful attention to health and fitness in school was not only because of a curriculum disconnected from the children's lives, a lack of voice for children, or teachers who were not interested in those issues. It also reflected the strains of an underfunded education system. One afternoon a teacher came to the class to see the posters on the walls the children had made. She told me "Yes, *Meme*, this is good because you have time to do this". I was curious to know why she reacted in this way and she casually continued. "We [the teachers] do not have time for this nonsense because we have too much to do," she said. "The Ministry of Education expects us to do so much for little pay while the school curriculum is also too congested and there is hardly time for anything". I asked her if health was not important and she replied with much frustration on her face, "Everything is important, but there is no time," It became clear during my time teaching at the local school that inclusion of health studies within the Natural Science and Health curriculum was hampered by the teachers' frustrations with the Ministry of Education. This frustration arose in part from their low wages, which many teachers said created higher levels of stress, a sense of demoralisation, and low motivation to do any tasks beyond essential teaching.[38] As many teachers in rural areas do not have professional teaching qualifications, they are paid significantly less than their qualified counterparts, which further frustrates teachers who see their workloads as equally as high and as demanding as those on higher pay.

Children's unseen participation and caring roles in hospitals and clinics

One of the key ways in which children in the Village gained and expressed agency was through acting as brokers, translators and mediators in clinical settings. One afternoon a few months after I started the study, Park, a small boy small in structure, came rushing into

[38] See the studies of Amukugo (1993), Iyambo (2012) and Amutenya (2016) which deal with the various factors contributing to Namibian teachers leaving the profession. In addition to what I was told by the local teacher in the village during the research, issues such as poor leadership, lack of professional development and huge administration burdens act as further contributing factors to the frustrations of teachers in local schools.

the class. Park had a beautiful smile and was always in a happy mood. He usually attracted everybody's attention and got everybody talking inside and outside the class. I observed Park for the first time, wearing no shoes and ragged clothes, when he was playing in the sand with a paper ball, as he often did during lunch breaks at the school. He had good negotiation skills and would always run to me, ready to begin bargaining about something, be it exchanging lunch or opening up another opportunity for himself. He would wait for me at my car, always eager to be my tour guide, and take me around the village at any opportunity available to him, before I eventually dropped him near his homestead or where he was herding animals. During my home visit to Park's house, I realised that it was more than the cattle that kept him busy, as he ran around fetching water and bringing out chairs for me and his grandmother. Smaller siblings would be seen around his homestead, with Park talking to them animatedly and instructing them in an authoritative manner not to disturb us during the conversations. I spoke mostly with him and his grandmother, and this reinforced his authority and seniority amongst his other siblings.

Coming back to the afternoon Park stormed into class, he apologised for being late, and looked tired and exhausted from the heat. He had not been at school during the day but decided on his way back from the local hospital that he still needed to come to the afternoon session. I was very surprised and expressed my thanks to him for taking time from his family and herding responsibilities. Although cheerful, Park seemed very weary and frustrated and seemed to have a lot on his mind. He looked at me and explained, as he ate the prepared lunch, that he had had to take his grandmother and sick sibling to the hospital. He then sipped some water and, while peeling a fruit, made a very interesting remark. “I am convinced that we, as children, help doctors and nurses with their daily work at the local clinic and hospital to do their work better.” He then almost angrily and emotionally looked at me, demanding my full attention, and said, “Children are not voiceless; they can speak for themselves. Children are not just cared for; they also take care of others, and children are not mere spectators; they do participate.”

As the whole group burst out laughing at Park’s serious voice, he immediately put aside his water and orange, and dramatically grabbed a broom and started to illustrate how he helped his grandmother to get to the local hospital and continued to explain how he would

explain to the doctors what he thought was wrong with his grandmother and sibling. Because of language barriers between his younger siblings, his grandmother and the doctors, his grandmother would communicate mostly through him about her health concerns. His participation in the whole process would further extend to include the doctors and nurses, turning to him after examining his grandmother and siblings and explaining how he needed to administer their medication, as the responsible person. He received additional instructions to bring his grandmother and siblings for follow-up visits either to the local clinic or hospital. He concluded, "Even if I only had to bring them back for a follow-up visit to the hospital, does that not count for a lot?"

This unplanned discussion provoked the reaction of the entire group and, with my permission, Beyoncé quickly put on my glasses and grabbed an odd piece of paper, pretending to read the cover from the plastic medication package given by the local clinics and hospitals which instructed how and when to take the medication. Her concern was the same as that of Park's, with regard to the language barrier. As most of the doctors at the hospital could not talk the local language, she therefore had to become the interpreter between the doctor and her grandmother, because her grandmother could not understand English very well.[39]

The children's vital roles as health brokers and carers was also evident in one interaction I had with Moricia. On the road a few kilometres outside the village, I got a friendly wave from Moricia. The girl was holding her grandmother's hand, who was wearing black sunglasses, and two of her younger siblings accompanied them. I stopped and Moricia informed me that she and her family were on their way to the hospital. I offered to take them in my car and the gesture was appreciated by her and the rest of her family. Moricia informed me that her grandmother was having a follow-up visit, as she was on a waiting list for a cataract operation. Moricia kept looking in the direction of her other siblings as she talked to me and explained that her siblings had severe diarrhoea and that the medication from the clinic had not helped. I offered to wait for them and take them back after their visit to the hospital and this gave Moricia a big smile on her face. She then requested me to

[39] There is currently a huge shortage of locally trained doctors in Namibia. This leads to the employment of foreign medical practitioners.

come along and accompany them into the hospital. Moricia took her family members and me to sit on long worn-down wooden benches behind a very long queue of other patients also waiting to see the doctor and then she made her way to the counter, taking out the green booklets containing their health history from her plastic bag and handing them to a lady sitting behind a glass counter. She was asked to make a payment, upon which Moricia informed the receptionist that she was unable to pay. The receptionist looked through the green booklets and told Moricia that her grandmother needed to proceed to another bench to wait to see the doctor for the follow-up visit, but informed her that her siblings needed to go back to the clinic to see a nurse because the hospital was unable to see them because the doctor had too many patients already waiting for that day. We proceeded to join the next queue, sitting in a very dark corridor with no working lights. After an hour, a nurse called the grandmother's surname and, when her grandmother didn't respond, Moricia stood up and led her grandmother by the hand in the direction of the nurse. They proceeded into the consultation room and the nurse quickly returned, to tell me that the grandmother had requested that I must also come in.

Inside I was greeted by the doctor, who had the green booklets of all the patients waiting outside lined up in a row in front of him. He immediately greeted us, saying "*Kuku*", and turned to Moricia, asking her to tell her grandmother to open her eyes widely while he proceeded to put on some surgical gloves. At first the grandmother became very anxious and struggled to open her eyes. The doctor again called on the help of Moricia and asked her to tell her grandmother that she needed to relax and try to open her eyes. Moricia conveyed the message and her grandmother started to smile. After the examination the doctor again turned to Moricia and asked if she knew whether her grandmother still had any eye ointment left. Without looking at her grandmother, Moricia responded that there was not much left, upon which the doctor wrote a prescription for her to go to the hospital pharmacy to collect more ointment for her grandmother's eyes. The doctor turned to me and asked if I was a family member and briefly explained that he had placed the grandmother on a waiting list but had no idea when she would be able to have the operation. While talking to me, the doctor wrote in the green booklet, making a note of the grandmother's next follow-up appointment, and handed it to Moricia. He concluded that he hoped that the operation would take place before the next follow-up

appointment and that she must continue to wear dark glasses and apply the ointment as previously recommended. We waited for Moricia for another hour before she came back with the ointment from the hospital pharmacy.

In their role as health brokers, the children experienced different levels and actors within the health system differently. Beyoncé explained the difference in her experiences with nurses and doctors. “Nurses,” she said, “should have been able to understand my grandparents’ and siblings’ needs more easily than the doctors, because they spoke the local language.” The nurses were mostly from the village and the surrounding country, yet they could be intolerant, rude, impatient and unprofessional, as many of the children reported. Beyoncé further explained that the nurses in the local clinic, some of whom were much older than the young trainee doctors, would be irritable, would entertain no discussion, and amidst their impatience would still expect children to take note of instructions how to help administer medication to grandparents and other siblings, who could not either read or were too old see the medication label or to understand. Beyoncé argued that, without her help, the nurse would not be able to perform her duties properly but that, as a child, her assistance was not seen or recognised. Her grandmother and siblings would be given follow-up dates to return to the clinic or given referral letters to go to the hospital, and their return would solely depend on her remembering those dates. For Beyoncé, if she had had a choice, she preferred the medical doctors because in her experience they showed more compassion and understanding.

Social proximity and medical confidentiality are critical factors here in how the children differentiated between doctors and nurses. As mentioned, most of the local doctors at the rural hospitals in Namibia are foreign nationals, from Cuba, Nigeria, Zimbabwe, and Zambia. While the doctors could, like the nurses, be equally abrupt and authoritative in their style of communication, the children felt they were more at ease in explaining personal matters to them and they sometimes would not seek medical help if they could not see a doctor. Doctors existed outside of the village hierarchy, and were not socially connected to any of the children. In contrast, the nurses lived within the village and were part of its social life and social networks. This meant that the children felt that when being treated by the doctors, they did not have to be as concerned that stigmatised illnesses or sensitive

discussions might be disclosed to relatives and neighbours. This further meant that by consulting doctors instead of nurses they would not cross paths with people on a regular basis who knew intimate, embarrassing or stigmatising details about their health histories. They knew nurses as neighbours, and it was deeply embarrassing to admit to neighbours that one suffered from a stigmatised illness.

Moreover, local hierarchies were visible in interactions between the nurses and the children. These hierarchies included the culturally widespread practice of children showing deference to local adults. This practice was exacerbated due to the higher status that local nurses felt they had achieved in leaving the village to be trained professionally. Both of these factors meant children often felt silenced, ignored and chastised by nurses who dismissed their perspectives and roles as carers in order to assert their own status in the local community as health professionals. Furthermore, the foreign doctors worked on renewable contracts that could be adversely affected by patient complaints and patients dissatisfied with doctors shared no social ties with these health professionals that might discourage them from complaining. In contrast, nurses worked on permanent contracts, and there was a limited supply of nurses within each rural area. Because of social obligations and ties, locals were much more hesitant to complain about a health professional from within their community. This, I observed, led to the doctors being more concerned with the satisfaction and opinions of their patients when compared with the nurses in the local clinics. Moreover, the workloads of the clinic nurses were extremely high when compared with those of the doctors, and their pay was much lower which, like the teachers, led to levels of fatigue and frustration, which often affected their interactions with patients and children.

Park expressed this attitude to me, saying that he felt it was better to visit the hospital than the clinic because the local nurses had no respect for the children who would accompany grandparents and siblings, and would yell and be frustrated instead of thanking them for bringing the sick patients to the clinic. The local nurses, he explained, would act as if they were not part of the broader community and seemed to have less understanding of the children's circumstances, even though they mostly came from the same area. Some of the girls in the group further related that they felt too afraid to even share anything personal

with nurses, and even when they themselves fell sick would prefer to be treated by a doctor.

The differences between the nurses and the doctors was made clear in one interaction I had with Moricia. After visiting the doctor in the hospital with Moricia and her grandmother, I had asked her if she wanted us to drive by the clinic to get health checks for her younger siblings on our way home. Moricia indicated to me that she was not keen to go and see the nurses alone because she felt they would be rude when she explained that the previous medication had not helped. She looked at me and said, "*Meme*, I think if you go along they will react differently and maybe give better medicine to help my siblings to get better." At the clinic, the queue was just as long as at the hospital, but one of the nurses spotted me and called me to come to the front, upon which I called Moricia and her siblings to come with me. The nurse first greeted me and then, in a very different tone of voice, asked Moricia what she did with the medication they gave her because it should have worked. Moricia had no time to give any answer before the nurse turned to me, complaining how the children neglected to follow instructions and then blamed the medications for not being good. She further told me that the girls were too lazy to boil water or to come and collect water purification pills and them (the clinic staff) were then blamed when the medication failed to work. She then turned to Moricia and told her that she was giving her some new medication that they had received that day and instructed her how to give the medication to her siblings. We left the clinic and Moricia told me that she felt so glad that I had taken the time to go with her to the clinic as she was sure that the nurses at the clinic would not have given her the 'new' medication if I was hadn't been with them. Moricia further remarked, "*Meme*, they kept giving me Panado [paracetamol pills] and nothing else." She was convinced the new medication consisting of a salt solution and some smaller pills to stop her siblings' bowels running had been in the clinic all along, but because of my presence the nurses had changed their minds and given her the correct medication. As we drove back to their homestead, she laughed, and said, "*Meme*, did you see the nurse was forced to talk to me although I did not reply. *Meme*, I am sure that she would have given me a long talking to and used a very loudly pitched voice so everyone could hear and then would have given me the same medication again." I asked Moricia what she felt the difference was between the doctor's service and that of the nurses at the local clinic. Morica immediately turned her back on me, as she turned her body angrily towards the door and looked out of my truck window. She looked into the distance and eventually turned back

and, looking into my direction, answered, "*Meme,* many of the nurses are from our village and they look down on us especially if you are not from their family. They do not know how to talk properly and treat you like nothing but the doctor does not know me and, for me, I am just somebody they need to help and so I like them better."

One day Messy asked me to take him and his sister to the local clinic. He further explained that his sister had been weak and had no appetite and his grandmother feared her condition would get worse during the night. As we drove to the clinic, I was keen to hear from Messy why he did not take his sister to the local hospital. He laughed and told me, "*Meme*, things do not work that way. If the nurses heard that I took my sister to the hospital instead of consulting them first, I would be in trouble. The nurses will not help you or will simply ignore you when you come back to the clinic at another time for help." I asked why he thought they reacted this way. Messy again laughed and said, "*Meme*, they think you do not obey them, and you disrespect them, and run to the doctors, but it is not like that, because sometimes they need to understand the doctor may know better."

At the clinic, I heard the nurse talking to Messy in a very loud voice from inside one of the consultation rooms. The nursing staff seemed angry that his sister had not been properly taken care of and asked Messy when she had last received a decent meal. Eventually, in a soft voice, Messy told the nurse, "I cook for her every morning but she just stopped eating and lost her appetite and that is why she is weak." The nurse reacted angrily, telling Messy, "I do not believe you." Messy insisted, "There is nothing wrong with my sister. She has just stopped eating and she is weak and that is why I brought her to you." The nurse continued to speak in a high pitched voice and instructed Messy about the medication prescribed for his sister and the follow-up appointment. The nurse then again reminded Messy that he needed to feed her better and more regularly.

Later, Messy seemed angry and upset. "*Meme*, these nurses do not know how to talk to people and they think they own the clinic, but it belongs to the government." Messy told me that in his view the nurses discriminated against the people from their own village because

they felt they knew much more than them. I asked Messy what he felt the difference was between the hospital doctors and the nurses, upon which he answered, “The doctors treat everybody the same and with respect and just want to do their job, while the nurses think that because they went and became nurses they are God.”

In my discussions with nurses, they told me that they encouraged people to come to the clinics first in order to prevent the hospitals from being overwhelmed. They explained that they often got frustrated with patients, including the children, when they saw people in their own community not following advice again and again or saw what they viewed as neglect. For nurses, health revolved around and depended upon basic forms of care, such as ensuring a family member was eating well. On the front line, the nurses dealt with the frustrating and ever reoccurring constraints of poverty and limited medical resources.
Seeing a six-year-old bring a two-year-old to the clinic was deeply exasperating for them, as they felt it reflected the difficulties and daily realities that families faced in dealing with major health issues.

Nurses needed to walk a fine line between being professional in their work and being a member of the local community. While the doctors lived mostly on hospital premises away from local communities, nurses lived in the same village as the children, and the nurses also had similar family care responsibilities and experiences of health and illness as the children faced in their own families. In order to be the health professional, the nurses felt they needed to show they were the stronger party and not to disclose that they were in the same difficult situation at home. Maintaining the hierarchy and the viewpoint of nurses being in a higher social position meant the nurses never acknowledged that their lives resembled those of the children. The nurses’ silence around conversations of shared illness experiences reflected a social distancing strategy by which hierarchy and work professionalism could be maintained within a small village social space (cf. Trnka, 2008).

Local healers

The children’s role as health brokers was limited to the biomedical sphere. They would acknowledge occasionally going to the traditional healer, accompanying their grandparents, but would leave their grandparents at the house, sometimes waiting outside or fetching the

parent later at their request. They explained that their grandparents did not need their help because they could mostly converse in the same language as the healer and it would invade their privacy and be disrespectful to listen to those conversations. When asked about this, Park started to laugh and said, “Its medicine my grandmother understands and it’s not given in a sealed container or pack but mostly in a herbal form which my grandmother will cook or administer herself.” Most of the children explained that they felt going to see the traditional healer was more conversational than the *ekonaakonolyopaufupi* [in and out] that they experienced with the biomedical staff; there were no long queues, and visits would sometimes be more than half an hour. The local traditional healer would do house visits for their grandparents or those family members that were bedridden. My young participants explained that they did not ever consult with a traditional healer for their own health concerns, although they recalled visiting them when much younger and when they were more dependent on the care of their guardians. Within traditional healer practices, the roles of adults and children as active versus passive actors in healthcare decisions are reinforced. The interactions also reveal the age when children become much more active in making their own decisions in regard to healthcare, and their shifting orientation towards the biomedical sphere as they age.

Traditional healing, while commonplace, exists outside the regulated state healthcare system in Namibia, and the state actively discourages these practices. This reveals that the type of biological citizenship that children are part of is *biomedical* citizenship. The literature on biopower and biological citizenship often presumes, from a western perspective, that the governing of the biological realm is grounded exclusively within a biomedical context (Foucault, 1975; Rose, 2007; Petryna, 2002). But in plural health settings, and indeed in non-western settings, the state may be actively trying to carve out its authority through a biomedical domain that is not assured and which competes with other understandings of the body and healing.

Conclusion

Throughout this chapter I have explored how children are capable of emerging as influential biomedical actors within a constrained environment, even when they are regarded ideally as the receptors of knowledge rather than the producers of it. I have revealed the ways in

which children navigate school health curriculums, finding spaces to devise “tactics” (de Certeau, 1984) through which they can assert their desires for education, basic resources and infrastructure, leisure time, recognition and a voice. As this chapter shows, children are active in connecting their families and older generations to state healthcare apparatuses, and in expanding the reach of biomedicine into domestic spaces. In doing so, however, they do not simply act on behalf of the state, but they challenge local hierarchies, take on adult responsibilities for wellbeing, and express their own desires and experiences. Structures of authority and power, as Foucault (1984) notes, are here generative and productive of agency and subjecthood, as well as modes of resistance. Children thus build active and sometimes rebellious selves vis-à-vis state, parental, clinical and school based modes of authority. This emerges because of the wide gap that exists between what the state, teachers, doctors, nurses and guardians expect of children and childhood, and the limited resources that are available for sustaining life and health in the village. In this gap, children take on responsibilities for themselves and for others that enables them to see themselves as vital actors in sustaining community wellbeing.

CHAPTER FIVE

My body and me: mapping dirt, hygiene and disease

Introduction: How children understand their bodies

In the village, the plains stretched toward the horizon, with the odd palm tree in the distance and the low water levels in the waterholes. During the day, a few elderly men from the village sat around the *cuca* shops, drinking their traditional beer and having informal discussions about the abundance of fish and the water pools left after the previous year's floods, while children would kick paper balls around in the dusty sand, leaving their faces and clothes covered in dust, looking as though they had been through a sand storm. Because of the low water level, the water becomes contaminated and dangerous to people's health. This in turn leads to wide range of illnesses that were commonplace in the daily lives of the children, such as diarrhoea, skin infections, and malaria.

This chapter explores how I used discussions around the body to enquire into the children's daily experiences of such illnesses, and the influence of their environment on their wellbeing. I used the body mapping, free listing and drawing exercises as entry points into descriptions of the children's challenges in relation to health and illness. Through these discussions, their experiences of the use of medications, the effects of medications on the children's bodies, and the experiences of the children associated with traditional versus biomedical medication became visible. In this chapter I seek to reveal the challenges the children face in keeping well, how they draw upon and integrate both local knowledge of the body, healing, dirt and pollution, and biomedical ideas, and the solutions they take in the face of constrained options.

Body mapping as method

The body mapping, free listing and drawing allowed the children to relate to their own physical body and experiences in ways that made some sensitive subjects, such as dirt, defecation, and hygiene easier to talk about. It left room for the children to discuss their daily circumstances at home, the school environment, and the school curriculum. The body

mapping and drawings further helped them to see their own body-sized image in front of them, sparking new observations about themselves. These methods helped with issues of body sensitivity and ethics, by making it possible to describe themselves without touching their own body but instead relating to the image which represented their individual bodies. Following each of the body mapping, drawing and free listing exercises, a group discussion took place and the children were all in agreement that they wanted to discuss each of the methods individually.

The body mapping sketches of internal body parts clearly resembled the common science textbook and the health posters displayed in the science classroom. During the individual interviews, in which students drew their bodies, children would start with internal drawings of the torso. They would first bow their heads, close their eyes in concentration, and think for a few seconds before they started. When I asked them why they paused to think, several replied that they were thinking of the poster on the wall and, with their eyes closed, would point in the direction of the school building. Others said, "I am thinking of my health textbook drawings and how the inside is represented and what's in our books in class and on the walls of the hospital and clinics." I often found them rubbing out what they had drawn, saying they wanted to "make it perfect" as illustrations appeared in the textbook or on the posters on the walls.[40]

During one individual interview, Pendacky carefully decided on the coloured pencils she wanted to use to describe where she hurt when she was sick. "I get sick easily specifically in my stomach, especially when the wind at school is blowing and making the smell of the dirty toilets even worse." "My pain starts in my stomach," she said, as she drew inside the body map and marked where she thought her stomach was positioned. She further continued, "This pain is sometimes so severe that it gives me headaches and my whole head hurts and I

[40] These observations related to the study by Lisa Mitchell (2006) amongst children in the Philippines, who also made use of body mapping exercises to determine the links between places on the body, injury and illness. Mitchell also realised that the children's representations of the interior of the body were influenced by what they had been taught and learnt in school or what teachers had told them and how it was prescribed that internal organs should look. Mitchell concluded that the whole exercise of body mapping advantaged the school system or, as I experienced during my study, showed the strong influence, power and authority of learning in schools and how the children based their information throughout the entire exercise on textbooks and other authoritative material, even when the children were outside the classroom during our individual discussion sessions

then need to rest." I asked her, "This pain in your stomach - is it just the dirty toilets and the smell or is there something else that also causes you to have pain?" She replied,

"Sometimes I feel pain in my neck and knees and my grandmother says that I fill the water cans too heavily and that is why I have neck and knee pains." Pendacky's face lit up as she told me, "My grandmother makes a drink from flowers (herbs) she picks nearby." I asked her where her grandmother got the herbs from and if they helped with her aches and pains. "Yes, yes, *Meme*, the flowers are the best and my grandmother collects them far away and cooks them in a pot. It does not smell that nice but it helps with everything like flu, chickenpox, headaches, and pain in the bones," Pendacky excitedly answers. "*Meme*, I will tell you everything. Our neighbours also come and collect some but recently they have been hard to find because of the drought and the flowers need a bit of rain to grow, my grandmother said. The plants had all died out in the area where we normally got it." I asked Pendacky what they used if they could not get hold of the herbs. "Not much because it's not the same as the medication we get at the clinic or hospital. The medication at the clinic does not really help and it is just not the same. My grandmother's medication always helps and I feel much better after it than the medication from the clinic." Penacky further explained that the medication from the clinic made her skin get small pimples, and she drew the pimples on the body map to show me where they appeared after using the medication from the clinic. Pendacky also told me that she normally got a very bad skin rash from using the toilets at school and, if there was not enough water, it made her whole body dark. "*Meme*, let me take a grey pencil to cover my body map because my skin is this same colour and it makes me feel very bad. Sometimes I do not stay in school because the children look funny at me and then my grandmother uses some ointment that she rubs in and it takes the rash away." I asked her where her grandmother got the ointment from. "My grandmother gets it from the same place she gets the flowers and she needs to dry the flowers on our roof and then makes it like the *mahangu* [pounded into a powder form] and rubs it on my skin. However, it is also not available now and I am worried because I need to be careful." I asked her if she could not get any medication from the local clinic. "No, *Meme*, their medication makes it worse and they told me that there is nothing they can do." Penacky became almost sad but quickly asked if she could draw her heart, upon which she took a red pencil and draw a heart in a love shape and this made her laugh.

Gendered norms and representations of the body were evident in these drawing. The girls displayed the influence of the media and would politely ask if they could draw their heart in a red love shape and not just a heart as it would normally be portrayed by textbooks. The girls would also add details to their hair and face, particularly detailing the eyes and lips, while most of the boys just drew the eyes and did not bother with any detail. The girls would also come back several times to fix most of their facial features and draw carefully to make it look more like them. Through discussions of their drawings, it became visible how their bodies, bodily stigma and health were differently gendered. Moricia Gal explained, for example, "I feel that I cannot use the toilets or do my thing anywhere at the school. For boys it's easy – they do not care – but for me it is difficult because I am a girl. I wait until I get home or somewhere nearby and then run for the bushes. It's better and nobody sees me." Beauty angrily said, "I do not use the toilets at school but wait until I get home to go to the bush. … I would rather go into the bush where the wind and sand takes care of it than get sick in a toilet which has taken ages for the government to empty and clean." It became clear from these narratives that the girls had clear defence mechanisms outlining how to protect themselves either from getting sick or from catching infections from the school toilets.

When the boys explained injuries like a broken arm, most of them did not make any attempt to draw it. Instead they would just show me the arm or leg that had been affected by the injury, providing lengthy discussions about how these occurred in school playground, from falling out of a tree, or from falling while they were herding. Elas explained with excitement, after taking his body map and drawing for me, "*Meme*, see here I broke my left arm and right leg once, falling off a moving donkey cart. I spent some time in hospital and had to be out of school for nearly three months. It's better now but sometimes when it is very cold at night I get pain in my arms and legs." I asked him if he took any medication. "No, *Meme*, my grandmother tells me the clinic's medication is poisonous and I am too young and my legs must grow, but the medication will hurt me." I asked what he did instead to get better. "Most of the time my grandmother gets herbs and rubs them in my skin. She struggles to find them now with the drought but still tells me to let my bones heal on their own." "Do you agree?, I asked. "Yes, I have no other way because my grandmother knows best." Elas

also told me he had had chickenpox and made some spots all over the body map to identify the areas. He also told me about his malaria experience.

> *Meme*, once I had malaria and the nurses at the local clinic could not say what was wrong with me. My grandmother said it was malaria but the nurses said "no" and I came home and then my grandmother helped me with her own medication. A few months later, when I went to the clinic, the nurse told me that my grandmother was right because the blood test had proved I had malaria.

Reflecting daily health and illness challenges

For both boys and girls, their practical health knowledge and solutions came predominately from their grandmothers, and relied upon both local traditional medical systems and biomedical ones.

> Wiseman: The stomach is so important [pointing at the body mapping]. My grandmother believes you need to keep your stomach clean and safe. She would cook some flowers [herbs] for us that she collected from the nearby area and then we would drink the water and it tasted extremely bitter, but it would clean us. She would especially do this after all the celebrations in the village, after the long holidays in December, and before going to school in the New Year. My grandmother believed we needed to start with a clean stomach.
>
> Rosa: Does she still do it?
>
> Wiseman: It is very hard for my grandmother to find the flowers because of the drought but she still tries her best to do it even by using some other flowers that she burns. We normally use those when we have colds and flu but now she says it's also to clean the stomach. [He laughs]. I think it keeps me safe from the problems others have at school because of the full, dirty toilets.
>
> Penacky: I try to keep away from the school toilets and prefer to wait until I get home in the afternoon. Once I went to the school toilet and got severely sick. My whole body became infected with things almost like small pimples, which

became watery and covered my whole body. [She shows me the black spots on her body, her legs and arms].

> Villax [boy]: I run around a lot on the school ground. I feel I cannot wait to get home to use the bush so I normally do not use the toilets at school but try to find a spot at school to do my thing [referring to defecation and urinating].
>
> Rosa: Why do you not use the toilets at school?
>
> Villax: My sisters used to get sick from using the toilets and my grandmother then told me to stay away.

Some of the children, particularly the nine-year-olds, just circled areas inside the body depicting where they would experience pain from diarrhoea, while the eleven-year-olds would give a more precise description of the lungs, the position of the heart and where the brain was situated. All of the children would first try to draw the stomach because this was where most of the pain would be felt when they experienced diarrhoea and gastro - intestinal diseases, followed by the brain which was mostly associated with the headaches that they constantly experienced. This order of priorities reflected the daily realities of illness for these children: the contaminated water, made worse by the drought, and the daily task of carrying heavy loads on their heads. The drawings could also be used to articulate a sense of wellbeing. Drawing a heart, they explained, resembled the joy they felt when they did not have any pain in their abdominal and head area.

Despite diarrhoea affecting many parts of the body beyond the stomach, the children focused upon this organ as a site of pain. A few of the children would talk about pain experiences in their anus area, but when I asked if they wanted to draw it or talk about it, all of them would just laugh, keeping their hands in front of their mouth, or quickly changed the topic. My research assistant explained that the children would never talk about that part of the body because it is culturally regarded as sacred and talking about it would expose it to attacks from evil spirits.

In a similar manner to our discussions about physical education, the children used the drawing exercises to express their desires for a healthier environment. Most of the discussions centred on their experiences of having no toilet at home or too few at the school and the effects it had on their health. In the free listing exercise, the children wrote down what illnesses they had had in the last two months and made lists of which illnesses they regarded in order of severe to moderate. Diarrhoea, skin rashes, headaches, flu, and infections in the eyes topped their lists for both the most recent and the most severe illnesses, while they classified malaria as a moderate illness. During this exercise, Boy-Boy looks at his free-listing section and quickly closed his diary. I asked him if he did not want to discuss any of the listed illnesses and he smiled, saying, "Not really … I was very sick and had many days out of school because I had a very bad stomach. My grandmother had to pay somebody to travel for days to get the proper herbs that my grandmother wanted to be picked and he eventually returned just before my death." "You must have been very sick," I commented. Boy-Boy covered his face with his diary and started to laugh. "Yes, *Meme*, that is what I felt like and what my grandmother also confirmed." "What made you so sick," I asked." "While herding the animals, I had drunk water from a waterhole that maybe had very old water and it was not only me that got sick but many others, too." "Why did you not go to the clinic?" I asked. "I went but the medication they gave me did not help and I was too weak to go back and instead waited for my grandmother's medication. The rain has not come for a very long time and the water is not good now. In the *oshana* we need to boil it but sometimes when I am herding the animals I get thirsty and have no choice." He took his body map and made a lot of circles in the stomach area and also added spots all over his body mapping figure. "I also had a bad skin rash and the water was also to blame, I think … When I got better all the medicines of my grandmother were finished and I had to take my other siblings to the clinic and they said the skin pimples were also because of the water."

Pretty told me that the free listing exercise was helpful because, "Sometimes you are too busy and forget what made you sick. I get headaches a lot and I am very much sick of the clinic just giving Panado [paracetamol pills]. The Panado in any case does not help. I try to stay out of the sun because I think the walk to school and spending long hours in the sun

makes my headache even worse." I asked her if she talked to her grandmother or any other person about her headaches.

> Yes, my grandmother tells me that I need to stay out of the sun and she cannot remember the herbs they used before Panado. She is also too old and has no means of collecting the herbs anymore and therefore also makes use of the medication given by the clinic and the hospital. I also get skin rashes and my eyes are not good because I get eye infections when my headache continues too long. The nurses only give me Panado every time but, after I told them about my eye infections, at last I have an appointment at the hospital.

Household chores, sweeping, flies and keeping the stomach clean

Boot and Cairncross (1993) define hygiene in a biomedical sense as "the practice of keeping oneself and one's surroundings clean, especially in order to prevent illness or the spread of infection." Hygiene comprises of two ideas: the avoidance of dirt and the prevention of disease. However, what constitutes dirt is, as anthropologists have amply shown, culturally ~~constituted. Mary Douglas (~~1966,145) argues that dirt is "matter out of place", essentially disorder. "There is no such thing as absolute dirt: it exists in the eye of the beholder."[41] She further explained that "in chasing dirt, in papering, decorating, tidying, we are not governed by anxiety to escape disease, but positively reordering our environment, making it conform to the ideal" (150).[42] Below I will discuss both concerns about dirt as the source of disease, and in relation to cultural notions of impurity and disorder.

[41] In an effort to explore cultural and social systems, Douglas (1966) asserted some remarkable theoretical arguments formed around purity and danger, gathered during her fieldwork period with the Lele in what was then Belgian Congo. Douglas' theoretical arguments were inspired by the ideas of Émile Durkheim, dealing with the model of religious anthropology, and therefore formed part of the ideologies of a structuralist anthropology inspired by her everyday personal life experiences. In her fieldwork, she obsessively ordered the communal and daily lives of the Lele through constant classification, re-ordering and reorganisation to adhere to what Douglas called "social and cultural practices".

[42] The concept of cleanliness, hygiene and dirt has been reflected on by numerous other anthropologists, such as Sjaak van der Geest (1998; 2007) in Ghana, Zweegers (2002) in Vietnam and specifically the work of Miranda van Reeuwijk (2001; 2003) who worked on children's practices and ideas on the topics of dirt, hygiene, disease transmission, diarrhoea and other gastro-intestinal diseases in Tchetti, Benin. The study of van Reeuwijk concluded that children are capable of constructing their own ideas around the aforementioned topics distinctly from those of adults and demonstrated that children's ideas on the inconvenience and challenges they had about defecating in the bush made the success of latrines more likely if such a programme was to be implemented. Her findings therefore further helped to guide health policies in Tchetti.

The girls talked in length about hygiene, dirt and diarrhoea, particularly in relation to their household chores and how important it was to keep the house clean to avoid illness. Sweeping was spoken of as a way of getting rid of any dirt that would lead to stomach upsets. The children explained that flies could lay eggs on open faeces and any food lying around, which would then cause people to become contaminated and ill. Nangy explained,

> I think sweeping is good because you get rid of most of the dirt by sweeping and making sure to sweep properly before the wind brings back all the dirt. It keeps away all germs and I think it keeps away any smell from anywhere. The stomach [pointing to the inner drawing of her body mapping] is so sensitive as soon as it enters your nose and mouth it goes to the stomach and it makes it sick, if there are awful things in the wind.

Here dirt is a general category for all dirty things on the ground, such as dust and rubbish, that do not belong in a house and therefore become associated with pollution, seeping into the air and becoming dangerous and infectious to her body. Nangy added,

> Sometimes people do not look after their small children properly. If they defecate, they do not pick up after the small child and flies are one of the other things that go around infecting food, humans, anything, leading to more stomach problems. Big people [adults] are sometimes drunk and forget to cover what came out of their body and we step in their things [faeces] and bring it home and therefore create more problems to the stomach. There is no water to wash away things that are dirty, and it makes it sticky and smelly and it is also not good for the stomach.

Here Nangy argues that adults have a crucial role to play in keeping children well, and criticises their irresponsible behaviour (such as drunkenness). Therefore, children can be active partners and important role models in healthy behaviour, even when they do not have as much power as the adults in their families.

This sense of responsibility to their domestic spheres was evident when the young participants showed me around their mostly traditional houses. They took great pride in

showing me the different rooms and spaces, even when the houses were simple or dilapidated. Here their role as homemakers and carers, responsible and observant of their household's needs, became clearly evident. Feeling responsible for the cleanliness of such spaces meant they had clear ideas about how things could be improved in their villages. Nangy explained that they needed "more toilets and some people to come and clean them on a daily basis", while Moricia felt, "The government must dig bigger holes and the things need go into the ground or they should make flushing toilets. We are not modern, living like a thousand years ago. Look, *Meme*, we have cell phones everywhere, why can we not have flushing toilets?" Candy also explained that she thought,

> The government does not take children seriously. When it comes to older people they get what they ask for but with us never. ... Maybe they want us to die first. They [the Namibian Government] must just give us more toilets and flushing toilets like at the state hospital and clinics. We can even take turns to keep them clean and then decide whether to wash our hands at the taps or like we do at home before we eat and after we have eaten.

Conclusion

João Biehl and Adriana Petryna (2013) highlight the importance of global health attending to the local lived experiences of at risk populations. This chapter has shown that the children's experiences of health involved daily navigation of environments that could make them sick, as they focused upon disordered and dangerous spaces containing *nyateka* (dirt), and the practices that could keep them *yogoka* (clean) and healthy. In doing so they were aware of their own "local biologies" (Lock, 2013; Lock & Nguyen, 2010), the particular way in which their physical and social environment shaped their chances of getting sick or staying well, and the types of ailments that were ever-present in their own and their families' lives. My young participants spoke about how their daily illness experiences were linked to the need for more serviced toilets in relation to student numbers, better food and the need for vegetable gardens at school. Equally they understood health not simply as an individual attribute, but as a condition that enabled them to perform their daily duties at home and to serve their grandparents and other family members. The use of body mapping and other exercises revealed how easily children can be involved in discussions about health and

solutions to illness, how carefully and insightfully they could reflect upon and articulate these concerns, and indeed, how significant their voices would be in contributing to health policies and programmes in the country (Nieuwenhuys, 1997; Mitchell, 2006).

CHAPTER SIX

Stigma, secrecy, in/visibility and HIV/AIDS

Introduction

This chapter focuses upon how children deal with and act upon the social realities of HIV/AIDS, and the resulting stigma, invisibility and secrecy that surround this illness. Ethnographically I will first focus on encounters with the parents and guardians of my young participants who, as gatekeepers for my research, were concerned about what my study might reveal regarding the stigmatized presence of HIV/AIDS in their households. I will then examine how the children themselves are confronted with and also are part of practices of stigma and secrecy surrounding AIDS. Through the use of photovoice, I began to understand the beliefs and practices that sustain social attitudes to AIDS. I will argue that children's enactment of agency in the realm of health depends upon how they experience and navigate the stigma, secrecy and in/visibility of taboo illnesses. Most anthropological discussion on AIDS focuses upon adults (e.g. Adams & Moyer, 2015; de Klerk, 2012; Engelmann & Kerh, 2015). The guardians in my study also talked on behalf of the children in an assertive effort to conceal AIDS. This adult-centric focus within anthropology and my field site leaves children out of any relevant discussions, be they academic, policy-based or health related. This chapter thus seeks to highlight children's views regarding how they coped socially with illnesses that were largely taboo and hidden.

Stigma

Stigma is defined by Erving Goffman (1963, 13) as "an undesirable or discrediting attribute." When individuals are marked by stigma, this often leads them to be socially shunned. As a consequence, those dealing with stigma would often rather avoid the shame of stigma through practices of secrecy, containment and concealment. Stigmatization can operate as an effective measure of social control as actors seek to avoid exposure, and can lead to isolation, social distancing and marginalisation. As Nancy Scheper-Hughes argues (1992, 373-374), "It is everything that makes us turn away from another human being in fear disgust, anger, pity, and loathing." She further states that, "to stigmatize another human being is the most antisocial of human acts, for it consigns the victim to a living death on the margins

of human interaction". For Scheper-Hughes, stigma is fundamentally "a discourse, a language of human relationships that relates self to other, normal to abnormal, healthy to sick, strong to the weak" and noted that it

> … involves all those exclusionary, dichotomous contradictions that allows us to draw safe boundaries around the acceptable, the permissible, the desirable, so as to contain our own fears and phobias about sickness, death, decay and madness.

She concluded that "the tactics of separation allow us to say that this person is *gente*, one of us and that person is *other*."

Even in "the age of treatment" (Moyer, 2015, 259), AIDS is still deeply stigmatised in Africa. Sub- Saharan Africa accounts for more than two-thirds (71 per cent) of the estimated 35.3 million people living with HIV around the world and, in 2012, the year before my fieldwork, it was noted that out of the total number of 2.3 million new infections, 1.6 million were from Sub-Saharan Africa (UNAIDS, 2013). Children account for more than nine per cent of the total number of 3.3 million in Sub-Saharan people living with HIV and 91 per cent of those children live in Sub-Saharan Africa. With more than 260,000 children newly infected in 2012, this amounted to nearly eleven per cent of the total number of new infections (UNICEF, 2013). According to Brown and colleagues (2003), HIV/AIDS was the most stigmatised illness in Africa, ranked higher than sexually transmitted diseases, epilepsy, mental illness, leprosy or tuberculosis. The secrecy generated by this stigma is a barrier to HIV prevention, as people fear that in disclosing their status they will be rejected and face discrimination within their communities.

Children's absence in discussions around AIDS

Children are often invisible in discussions of HIV/AIDS. Geoff Foster (2006) argues that children are not the focus of governmental and non- governmental approaches to HIV/AIDS: with statistics focusing on mothers infected with HIV, data on children is often simply not collected. For example, while we know that 2.3 per cent of adults between the ages of 15 and 19 years in Namibia are living with the disease, the last *Namibia Demographic and Health Survey* (NDHS) in 2013 /2014 collected no statistics on the prevalence data for

children fourteen or younger (MoHSS & ICF International, 2014). This is mirrored in other African nations. Akello-Ayebare (2008) found that in Uganda health programmes focused upon providing adequate health and statistics concentrated on the 0-5 age group, where immunisation and other paediatric necessities are prioritized in order to meet international goals regarding infant mortality, a key marker of a developing nation's 'progress'. In both Namibia and Uganda, because of the sexually transmitted nature of HIV, emphasis focuses upon the sexually active group of youths aged fifteen to nineteen years. These health priorities leave the six to fourteen-year-old age group largely invisible in terms of governmental priorities in public health and HIV prevention.

The current HIV prevalence rates in terms of age groups and woman attending anti-natal care in Namibia is summarised below, with the children's figures only an estimate.[43]

Indicator	**Year**	**Prevalence**	**Source**
Estimated National HIV prevalence in children (0 - 14)	2013	2.6 %	MoHSS & ICF International (2014)
National HIV prevalence in older adolescents (15 - 19)	2013	2.3 %	MoHSS & ICF International (2014)
National HIV prevalence in general population (15 - 49)	2013	14.0 %	MoHSS & ICF International (2014)
National HIV prevalence in pregnant women using anti-natal care (15 - 49)	2014	16.9 %	MoHSS & ICF International (2014)

[43] Therefore, in order to determine the HIV prevalence rates in this age group (0-14) in Namibia, in the absence of any data, it becomes necessary to use the Estimates and Projections Package (EPP) compiled by WHO and UNAIDS (Morgan et.al, 2006). Its authors argue this should not be regarded as the official prevalence rate as the accurateness depended on the information gathered in the survey. By using the data gathered by the Sentinel study prior to the NDHS study, the prevalence of HIV in the 0-14 age group is estimated to be about 2.6 per cent and, taking into account that 10 per cent of people living with HIV are children aged 0-14 (MoHSS & ICF International, 2014), it can be estimated that children in this specific group would already have reached the adolescent category.

Scholars have argued that in order to address the needs of children affected by HIV at a policy level, the children's voices themselves must be central.[44] This is because children are highly affected by their HIV/AIDS status as well as by their parents' HIV status. Those who are infected must learn to live with and minimise the impact of their disease. They furthermore suffer hugely in seeing their mothers and fathers die, having to struggle with their sickness, often through providing care, and then find a place within the extended family to reside and be supported. This often puts pressure on elderly siblings to become responsible and care for younger siblings, as I discuss throughout this thesis. These issues are particularly pressing in my field site, as this region has the fifth highest HIV prevalence rate among the thirteen regions in Namibia, at 15.6 per cent (MoHSS & ICF International, 2014), and more than a quarter of all households have experienced an HIV-related death in the family (MoHSS, 2009).

Twenty-two of my participants never knew their mother or father and at an early stage of their life experienced displacement from their family household.[45] As I will discuss in Chapters Seven and Eight, the non-school attending children could not be placed with extended family members because those households were already overburdened with

[44] Lorraine Sherr and colleagues (2014) argued that irrespective of all the advances and recommendations made with regards to the AIDS response there is "a gap in omission", meaning children are lost when it comes to basic involvement in making decisions about their needs and concerns in the AIDS crisis today. Sherr and colleagues added that polices are designed, handled and framed at a higher level by adults and concluded that if children are continuously excluded from policies and discussions it will be like "Hamlet without the Prince". In an assertive effort to advocate for children in the continued AIDS crisis, Alex de Waal and colleagues (2008) urged for the inclusion of children in development policies and highlighted Sub-Saharan Africa as the countries which have the largest numbers of children that have lost one or both parents, in the process mentioning that more than 12 million children have been orphaned or affected, causing serious challenges, sufferings and misery. Discussion by de Waal and colleagues (2008) argued that, regardless of this enormous total, it did not seem that children were taken seriously enough when it came to their inclusion in policy reforms and that policy makers ignored the underlying complications. Their arguments centred on the emphasis of policies needing to shift so as not to concentrate on individual children but to devise policies and solutions that could deal with the range of challenges facing all poor and needy children. The authors acknowledge the huge challenges, difficulties and impact that AIDS has on children and that the answer is not simple, but plea for the recognition of children as part of the AIDS epidemic and the important part they might play in policy formulation. One of the conclusions made by the authors was that practices in terms of placing children in certain categories, such as orphans, children affected by and/or infected by AIDS, which leads to more stigma should be removed and children regarded simply as children.

[45] I am not specifically stating whether their parents died of AIDS, or how many of the children themselves were HIV positive. As will be discussed, this was not a topic I was able to address, or felt comfortable raising, due to the stigma of HIV/AIDS, as well as the wishes of the guardians to not broach this topic with the children. Therefore, the stigma and secrecy surrounding AIDS extends into my ability to write about this topic.

taking in other destitute family members and orphaned children. As for the 22 school-going children, 21 stayed or were placed with their grandparents, and currently were at a stage when those grandparents were ageing and in need of care themselves, making the burden so much greater on the older siblings.

Gatekeepers and hidden concerns

A letter translated into both Oshiwambo and English formally inviting guardians and parents to the school to hear about my research was sent with the help of the school principal (see Appendices F & G). I compiled a cover letter for the parents and guardians of each of the young participants to formally introduce myself as the researcher, to explain the nature of my study and to get their signed and verbal consent.[46] After my introduction and a lengthy explanation of my study, I gave the guardians the opportunity to ask some questions. For a few seconds it was silent in the room, when the first guardian got up, greeted me politely, and followed his greeting with the first question, "Are you coming to talk about HIV/AIDS to our children? I am sick of people coming to talk about HIV/AIDS." He continued, "Every time, I hear HIV, HIV, HIV. Is there not something else we can talk about?" He further continued, "It's all over the place, in the church, on every corner [billboards] in town, and it just never ends and it's actually a private matter."

Caregivers often talked on behalf of children, saying that children were also sick of hearing about HIV/AIDS. As one caregiver phrased it, "HIV, HIV and HIV, and they do not have time ~~to waste." Another caregiver~~ said, "If you want to waste the children's time talking about HIV, its better they come home and do their chores instead of wasting their time." In a similar vein, one elderly grandparent who held his walking stick firmly and was barely in a position to move from his seat on his own looked in my direction with his eyes closed, cleared his throat and eventually replied, 'We are grateful for you coming to this particular small village and it's about what the children can learn for their futures that is important, and being healthy is important to everybody'. He looked around the room with authority,

[46] Two separate meetings took place to obtain my consent from the guardians and the children. After gaining the consent of the guardians, I met the same afternoon separately with the children to obtain their consent. The children also received a formal invitation (Appendices H & I) and then signed a consent form (Appendices D & E).

and all of the other family members concurred that if my study was about *health*, it would be important.

The adults' comments and concerns revealed the active involvement and visibility of state institutions, non-governmental institutions, and churches in HIV public awareness initiatives. This also revealed their resentment and tiredness of these public health messages and AIDS discussions, which dominated governmental engagements and investments in their region. These were often at the expense of other concerns, such as investment in basic infrastructure. I too noticed the prolific number of billboards and public messages that sought to educate the public of this region about the risk of HIV. Many local people resented this, believing that it stigmatised them in the eyes of fellow Namibians as a vulnerable and at risk community suffering heavily from AIDS, and that this was how they were primarily known to outsiders.

This strategy was likely also an attempt by caregivers to protect their families and children from me as a researcher finding out about their own and their relatives' HIV status. They were further worried about the risk that these health secrets could then become public knowledge in the village and beyond. As the children were present at these initial meetings, these comments also were also a way to communicate to the children that they should not discuss or disclose these issues with me. As Goffman (1963, 11) argues, stigma involves "bodily signs designed to expose something unusual and bad about the moral status of the signifier." In this case, the guardians wished to avoid me observing, or the children revealing, any signs such as withered bodies, ARV medications, or hidden rooms for the bedridden, that would expose the supposed moral failings behind HIV. As nearly all locals were Christians, HIV socially signified unchristian acts and practices, such as sexual promiscuity, witchcraft, and jealous neighbours, which many locals believed were the root causes of HIV infections (Thomas, 2007; Rödlach, 2006).

During my home visits I had another encounter, which further marked the great concern of gatekeepers to conceal in every possible way the fact that they had a bedridden patient in the homestead or any person in the homestead using ARV medication. One exercise I did with the children was to discuss the medications used for the entire household. The

guardians were quick to instruct the children not to fetch the medications, and mostly collected different medicines from around the huts themselves. The guardians would reveal or show only certain medicines and health products, such as vitamin supplements. However, such medicines themselves also marked the presence of HIV, for vitamins are commonly given to ARV users as supplementary to the medications. They also were quick to show me other medicines for flu, stomach upsets and other common ailments, but I was never shown ARVs by any of the guardians.

Figure 10: Pharmaceutical medications

The children were, however, sometimes not as discreet. While I was visiting the homestead where Nangy lived, we were discussing the medications used in the household. Nangy had collected a range of bottles, which included vitamins, paracetamol, and diarrhoea medication, and she reminded her grandmother of the pills that Nangy had recently collected from the local hospital. "*Kuku*, can I go fetch that medication to show *Meme*?" The grandmother looked at her sharply, and said, "It's not important, and it's like all the others in front of us that matter". During an individual discussion with Nangy she told me that the medication she was not allowed to show contained pills meant for her bedridden aunt who was present in the hut but behind closed doors when I visited them on that particular day. This reveals how children are actively encouraged to participate in the concealment of

particular illnesses and therapeutic practices within domestic settings, but they do not always comply. This concealment can have negative effects on individual's health. As scholars have noted, this can weaken the drug's efficacy, because patients refuse to take their medications with them out in public, which can mean missing doses at the prescribed times, an essential practice to ensure the drugs work (Niehaus, 2015, Pride, 2013).

Photovoice: dealing with stigma and ethical challenges

In order to help the children discuss topics that they found hard to put into words, I introduced the method of photo voice. I bought 30 disposable cameras for the children.[47]

The participants were allowed to take seventeen photos of their choice and ten photos that were specifically about the medicines used in their homesteads, the food they ate and the preparation of the food, fruit and vegetables they grew, and their livestock. In previous discussions with the children, I learned that only one of the 26 participants had ever handled a camera. The children had the opportunity to test the cameras at school inside the classroom and we had a small excursion outside and they walked around the school grounds to take some photos within the confined area of the school.[48] The pictures taken by the participants described what was important to them within their home environment and were used to provide topics for discussion during our individual discussions, giving the children space to talk freely and openly by looking at the pictures they had captured. It was a way of seeing things through another lens.[49] At the local school itself I could not find a private space for the individual discussions but negotiated with a

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[47] I also bought four extra disposable cameras in case of emergency, each of which could capture a total of 27 photos per camera.

[48] Testing the cameras gave the children the chance to ask more questions and see how the disposable cameras would work inside and outside where there was different light and darkness. The method of photovoice has been used by various other researchers (Baker et al., 1996; Wang & Buris, 1997; Strack et al., 2004; Fournier et al., 2014; Dakin et al., 2015) especially in marginalised communities to reflect on the communities daily lives and surroundings.

[49] The study of Mienke van der Brug (2007; 2011), in northern Namibia where she used the 'Kids Club Method' to relate to experiences of children orphaned by AIDS, noted the importance of having a comfortable relaxed space where the interviews could take place. She argued that if the children's environment was conducive to comfort it would enhance discussions.

school teacher who provided a room in her house situated on the school premises[50] for children to discuss their photos with me in private. I found that this arrangement greatly contributed to the children being open and relaxed. This method enabled me to have a closer look into their daily home environments, in combination with what we they drew, wrote in their open and closed diaries, free listed and sketched in the body mapping exercise. Taking most of the photographs with me present, as well as our later reflections on them, enabled them to concretely record and continue discussing with me some of the things, places, issues and events that had already been brought up in drawings, in their diaries, body mapping and free listing exercises.[51] The children were very proud to be helping me as researchers and alongside me in their role as photographers (c.f. Christensen, 2004).[52]

While my young participants found this method empowering, it did create some ethical dilemmas for them and for me. While preparing for the photovoice activity, the children had a detailed discussion of how they felt about of whom and what they wanted to take photos. The children's discussion reflected their own daily realities of living amongst people who were bedridden and, in most cases, neglected and lying naked. The children were quick to say that they would not take photographs of naked people because it would be disrespectful, adding that taking photos of bedridden sickly people would be bad because the people could not defend themselves. The photos they were eager to take were of their dogs, cats, cows, goats, animals, brothers, sisters and grandparents. They agreed that all the photos would only be from their own homestead and not outside or of any families and households in the surrounding area.

[50] Most Namibian rural schools have houses for teachers on the premises providing accommodation to teachers and families from other towns or regions.

[51] Discussions about the photographs themselves would be open ended with them dividing the pictures into two sets. The seventeen personal photos and then the ten photos that would be used in our discussions, but conversations might involve either set of photos thereby not restricting the child but just focusing on one part of their life.

[52] The seventeen photos taken by the participants were put in a photo album and given to them before I left the field and, by agreement, the ten photos of a certain theme were taken and kept by me and followed up with detailed individual discussion sessions.

Another concern related to fears of witchcraft. Most of the children had never seen a picture of themselves before because many people in the village believed that photos could be used by the photographer, who might themselves be a jealous neighbour, or might be under the influence of one, to perform witchcraft. The children and I then reached an agreement that they could only do this exercise at home if they negotiated the terms and conditions with their guardians or parents if they would grant them permission.[53] All the children came back the following day with permission from their guardians and took the cameras home for a week before I arranged the associated home visit.[54]

Figure 11: Cameras

The photos revealed a range of perspectives on how children navigated and dealt with illness related stigma in their daily life. In particular, a photo of a closed door (Figure 12) was particularly poignant and symbolic. In my private reflections with Nangy, she held a photo tightly under the table on her lap that showed a closed door and then slowly put it on the table.

[53] As they were so excited to use the cameras, we also decided it was important that they could not lie about being granted permission by their guardians because I would be informed of such decision during my home visits. Home visits always took place with a pre-arranged appointment through my participants to visit their homes. All home visits took place in the presence of their guardians and I never went to their homesteads if I was not invited.

[54] We discussed the issue of possible damage to the cameras, for example falling into the water, or a picture being too dark. The children were worried that they would end up having no pictures in the event of anything happening to the disposable cameras and came up with the idea of me taking photos with my own camera alongside them during my home visit, to ensure that there was another set of photos taken and they would definitely end up having some photos. A detailed timetable was compiled with the specific date and time I could come to their individual homesteads to take the photos with them. All the cameras were placed in a zip-lock bag for them to take home. Despite my worries, all the cameras were safely returned and all the photos were developed and came out beautifully.

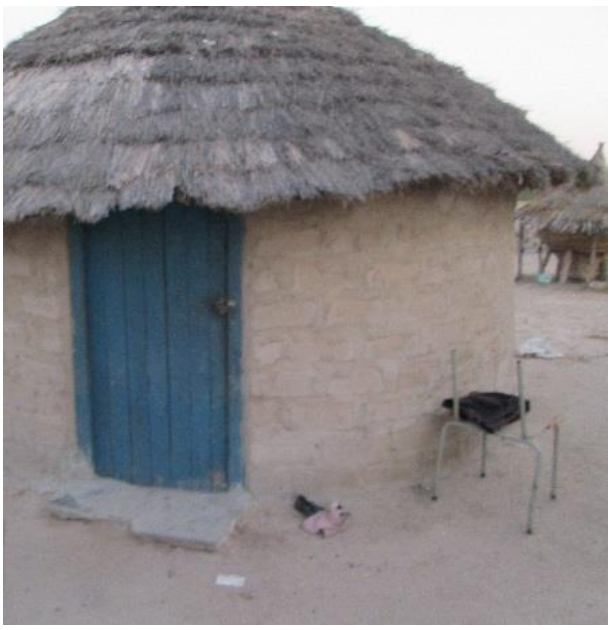

Figure 12: Nangy's photograph of the closed door of her sister's room

I congratulated her on the beautiful photo. When I asked her why she had photographed a closed door, she explained that the photo was about her eldest sister being behind the door, who had died a few years earlier. Nangy explained that her sister had been very sick and she felt that taking a photo of the door would remind her of her beautiful sister behind the door. Nangy was still for a while, staring through the window, and then told me that before she got sick she felt her sister was the most beautiful person she had ever seen. She said her sister went to the capital city to work and came home during the festive seasons, bringing beautiful clothes and lots to eat. However, her sister then returned earlier than the normal festive season during the time of my fieldwork and became sick and weak to the extent that she could not walk, talk or eat on her own any more. In a much softer voice, Nangy explained, “Maybe you know Windhoek [the capital city] and know what happened to my sister because she was healthy when she left the homestead.” A worried Nangy looked at the photo and said she continually asked her grandmother why her sister got sick and died but she also did not know,. She said her grandmother had replied that it was the family’s own private problem, and the two of them had to care for her and not to tell any

one else about her illness. Nangy said that people in the village had tried to come and visit her sister, but her grandmother refused to let them see her.

She further explained that she wanted her grandmother to show me the medication she collected for her sick aunt from the local hospital the day before, but her grandmother refused. Nobody besides herself and her grandmother was allowed to go into the room where her aunt was lying. I wanted to know why she felt I had to see the aunt's medication. She replied, "Maybe you could tell me why my aunt is so weak and sick and maybe what is wrong with her, because nobody wants to talk about her illness." I wanted to know if she had spoken to anybody at the hospital regarding her aunt or her sister's conditions. Nangy responded that she was just given the medication by the doctors and explained that her sister could not stay at the hospital and was sent back to be taken care of at home. Nangy angrily told me that the hospital was too full and there was no time for any staff to give her explanations because so many patients were waiting to be helped. At this point I realised that Nangy did now know for sure what illness her sister had suffered from, and that both her guardian and the doctors had participated in concealing this diagnosis from her. Not knowing made Nangy feel both angry and helpless to make sense of her sister's passing.

Nangy explained that she knew there were many other families in the village that had sick relatives coming from the capital city who also "hid" them. She would see them at the local hospital. When I asked her if she knew what happened to those that were being hidden, she replied, making no eye contact but in a matter of fact manner,

> Obviously they die. We have many funerals, but they come and go, and no one asks any questions or gets any answers about why people die here in our village. I asked my cousin who came for a visit if she knew why my aunt was so sick and she said its HIV and warned me not to tell anybody.

Nangy further told me how she cried for a few days as she knew her aunt would die because they learnt in school that there was no cure. She then said to me, trying to bring a smile to her sad face, "I told you I want to become a nurse and then I will know all the answers and be able to help others, especially children that are confused." This comment reveals that children have a real sense of being excluded from information about HIV, illness and death

in the Village. This is part of the wider community strategy of concealment and secrecy, for it seeks to ensure children cannot be active in the spreading of stigmatised information between households. However, children gather knowledge from their own observations, discussions with other children, and information learned at school, to draw their own conclusions out of the silences. However, they are not able to share and emotionally process these realities within family settings, creating further cycles of secrecy.

A discussion with another of my young participants also evoked a powerful description of stigma and how children deal with it on a daily basis. It also revealed the ways in which stigma negatively impacted on the children's ability to deal with death and grief. I sat with Elias who barely wanted to talk about the photos displayed on the table. This was in sharp contrast to the enthusiasm with which he had taken up the photovoice challenge. He sat and looked at all the photos and told me, "*Meme*, you came one year too late." He gazed outside the window. "These photos are OK, but if you came last year I could have taken a photo of my big uncle and had the picture forever." I asked why he could not take that photo and he answered with real frustration,

> OK, I will go to his grave and take one there. I just wanted to have a photo of his face because he taught me how to fish after my father died and so many other things. He was the one who promised to take me to the mine soon and now he is no more.[55] If I had a photo of his face it would have been so nice. Then I would have something of somebody who I knew and cared for me.

He further explained that his uncle had come home sick from the mine and never got out of bed again. When I asked him if he knew what was wrong, he was quick to tell me, "I do know what they call the sickness, but nobody talks about it, but it's what everybody dies of when they come back from the mines or from Windhoek. And everybody that stays behind does not talk and the person who dies, they die with the secret." I asked what he meant by the secret and he smiled and said,

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[55] "No more" in the context meant the person died or passed on.

> It's a secret what we are talking about now, and you will not tell my grandmother. I am angry about these secrets because there is no explanation given to us children when people suddenly turn up sick and then die, and we don't know what is happening. I was angry at my uncle for lying there and once I asked him what was wrong with him, and he simply did not want to answer.

When I ask Elias if he knew what the sickness was called, he simply replied, "You, *Meme*, also know it's HIV." Elias laughed with relief, and both of us started to laugh. Elias continued to explain that the older people did not want to talk about HIV. He recounted once trying to have a conversation with his science teacher, who became furious and almost gave him a slap. However, a visiting U.S. volunteer,[56] who he helped show around the village, explained to him about HIV and answered most of his questions, which, he said, made him feel much better.

Some of the children involved in my research would go to great lengths to concealing their own HIV status. On one occasion when I visited the hospital and specifically the ARV section, I stumbled upon one of my young participants who I will not name and, after he made brief eye contact with me, he jumped from his seat and stormed out of the room. The nurse in charge then came out and called his name but he never returned. On another occasion, and on the very last day of my fieldwork, I had to collect my homestay mother's sickly son from the ARV clinic. As I entered the waiting room where all the HIV patients were patiently waiting for their ARV medication, I saw another young participant. As I was very excited to see her, and without consciously realising the place she waited in, she immediately turned her face towards the wall. I felt she did not want to talk to me and that I would not force it, because I realised that she had immediately sensed that I knew she was positive. During my fieldwork some of my discussions with the children made me deeply sad, and at this moment I had to leave the waiting room and try as hard as possible to conceal my tears. I was angry at myself for not picking up this fact through her being absent at certain times of the month, when patients collect their medication, as I had just assumed she had other things to do. I felt angry because I thought perhaps I could have done more during the time I was there, to help these HIV positive children discuss their

[56] The United States deploys volunteers every year, mainly into the rural areas, to help teachers in classes.

health and concerns in a safe space. However, as previously mentioned, the children's HIV status was not a criterion for them to participate in the research, and I was careful not to ask about it, due to their guardians' concerns. I felt caught in a double-bind here, not wanting to exacerbate their stigma through making their illness visible, but by not giving space for the children to discuss the topic I was perhaps contributing to the secrecy and stigma around it. Two of my young participants have died since I left the field.

Conclusion

As Morris (1992, 27) shows, silences have multiple meanings. "Silences are not all identical, of course, but convey a wide range of significance, from the contemplative depth of a pregnant pause to outrage, disbelief, and stunned wonder". This chapter has revealed a range of silences, from communities, guardians, children and even myself. In many cases, people kept silences in order to prevent further suffering, to stop the physical demise of ill people becoming the moral demise of individual and families' reputations and community status. Yet for the children these silences did not feel protective but rather excluding and confusing. Morris argues that, "The basic opposition between voice and silence matters … because suffering, like pain, with which it so often intermingles, exists in part beyond language" (1992, 27). Stigma, I would argue, is one of the key ways in which suffering becomes indescribable. This is not simply because people cannot find the right words to express their pain, but because those words are dangerous in what they can do, and the consequences of voice threaten people already in situations of precarity. However, the children sometimes offered another understanding of such words, as if enabling the constant death and subsequent grief that threatened and punctuated their lives to be made meaningful and comprehensible.

While children are part of family and community practices that reflect and enable secrecy and stigma, as the two participants who I ran into in the hospital revealed, they also subtly challenge these norms through covert talk, through knowing even when they are not meant to know, and through making the material traces of HIV visible, even indirectly through a seemingly innocuous photo of a door. Here agency reveals how small acts of resistance are fashioned within and out of social obligations, roles and duties, which challenges the conceptual opposition between resistance and compliance and cooperation.

CHAPTER SEVEN

Responsibility and reciprocity: children's family care work

"Working is what we do; that's our life. Without doing our chores I feel empty and ashamed." – Moricia

Introduction

What first struck me upon arriving in the village was that, according to my own assumptions, the roles of parents/guardians and children seemed to be reversed in relation to practices of care. This chapter seeks to develop a "childhood ethics of care" to better understand these practices. This childhood ethics of care emerges at the margins of the state, in the context of limited support from government welfare, and outside the boundaries of the institutional support of local hospitals and clinics. The purpose of this chapter is to examine how children develop an ethics of care, challenging a western expectation that juxtaposes adulthood as a period of labour intensive care work and childhood as a period of vulnerable, playful dependence (Evers et al., 2011, 3).

During my time spent with the children, I observed that there was a gendered difference in the chores they carried out in and around the households. In the households of both the boys they needed to cook and look after some children, but had more independence and were not involved with any intense care of sick people. Acknowledging this difference, this chapter focuses on the healthcare and childcare work performed by both girls and boys.
This labour had become a crucial, although often publically invisible, part of rural household economies in Namibia. In detailing this labour, I show both the huge challenges that HIV/AIDS presents and the gendered labour burden it places on households and orphaned children, as well as the agency, relationships, security and sense of purpose that girls and boys built within these roles.

Numerous discussions in southern Africa anthropology focus upon this topic of care and support given by children to their families (e.g. Radstake, 2000) and child labour (e.g. Levine, 2000; Nieuwenhuys, 1994; Reynolds, 1991). Debates about child care and labour play out

against a backdrop of global humanitarian discourses regarding human rights, labour rights, and children's rights. Evers and colleagues (2011, 3) argue that African children are often seen as passive figures, "victims of war, poverty and illness, and not as agents who creatively deal with possibilities and constrains of social life". Such debates often fail to recognise different cultural conceptions of childhood, varied domestic family structures and the western centric nature of arguments around child labour. With these global pressures, the 'problem' of care for children is often expressed in the Namibian media, and present in debates surrounding national legislation seeking to safeguard children's rights and the future of rural, vulnerable children. In this chapter I argue that while children's responsibilities toward family might seem on the surface to indicate a lack of freedom, independence and choice, it is in fact a realm in which they express and exercise agency- through-care. I thus propose a *childhood ethics of care* that seeks to understand how care practices are distributed within a family that lacks many resources, deals with significant illness burdens, and must adapt to changing kinship norms.[57]

Circuits of care in the village

As Cecil Helman (2007) points out in relation to understanding an ethics of care, care for the sick predominantly occurs as an invisible, private labour, alongside and entangled with biomedical domains, the paid economy and expert advice. The children in this study performed a range of care responsibilities defined as *esiloshimpwiyu,* meaning "holistic home care" in the Oshiwambo language. Their care work in families included care for bedridden members of the family, frail grandparents and younger siblings. For children aged nine to twelve years old, their care duties could be multiple and complex. They were old enough to look after themselves, look after the younger children and babies, and responsible and physically strong enough to also care for adults. With the elderly and very young dependent on others, teenagers attending school elsewhere, and the healthy adults needing to work outside the home, they were vital to the daily running of the households. Their activities ranged from administering medication, taking the sick and frail to the local

[57] See also the work of Paul Farmer (2003), in his compelling anthropological discussion of HIV in Haiti and Boston, giving a thick description of the people involved and their continued struggles against a failed state, poverty and unequal power relations and his continued quest for access to health care systems.

hospital and local clinic, cooking, fetching water, washing clothes, washing sick relatives, and overseeing the household affairs in general. Their work was crucial for making the situation of family members bearable and much more comfortable, and was essential in the ongoing functioning of these families.

Childhood care ethics are not discreet but emerge within a range of new familial care ethics. Grandparents, for example, have also had to develop a new mode of care work and, in the midst of the HIV crises, have cared for orphans, grandchildren, great grandchildren and even their own dying biological children. Grandparents eventually come to rely upon young family members, including some who are still children, to share this care labour.[58] These care arrangements are not always easy however, and can cause stress and conflict, and reflect the costs of poverty and strained state resources. For example, Kalomo (2015) studied elderly woman in Namibia who supported many dependent orphans, and had high rates of depression. Many of these elderly, poor woman, taking up their customary duty to care for their grandchildren, were unable to meet those orphans' basic needs. Moreover, according to a UNICEF (2011) report on children and HIV and AIDS in Namibia, these families are affected by a lack of government welfare and support, as well as the unequal distribution of wealth in the country, with most rural children living in poverty with a lack of access to adequate public healthcare.

An ethics of care

This chapter seeks to challenge ideas about agency as a process of gaining independence and asserting one's will. Rather, as Laidlaw (2000) shows, agency at its heart involves the role of being responsible for things, ideas, events and people. I wish to extend his analysis of the relational nature of agency by arguing that it is not only constituted through responsibility, but through practice of care and their links to responsibility. As Susanna

[58] A newspaper article in the local *Die Republikein* newspaper (Tjijombo, 2015) reported a three-year-old boy looking after his blind grandmother in the north-eastern part of Namibia. Another recent newspaper article in the *New Era* newspaper reported that bail had been granted bail to a pensioner for chaining her grandson up because of her need to have him around to help her (Pensioner granted bail, 2015). These examples further relate to the persistent crisis in Namibia where a huge need exists for the state to put measures in place to support the elderly who, in the past and still to some extent today, are slowly starting to change in terms of caring for orphans, grandchildren and biological children.

Trnka and Catherine Trundle argue, “relations of care … are constituted through the dual aspects of recognition and action motivated by one's commitment to the welfare of the other” (Trnka & Trundle, 2014, 7). Discussions of care have often sought to challenge the focus within ethics, philosophy and politics on individual rights and empowerment. As Carol Gilligan (1998, 342) explains,

> … human lives are interwoven in a myriad of subtle and not subtle ways. From this standpoint, the conception of the separate self appears intrinsically problematic, conjuring up the image of rational man, acting out a relationship with the inner and outer world. Such autonomy, rather than being the bedrock for solving psychological and moral problems itself becomes the problem, signifying a disconnection from emotions and a blindness to relationships which sets the stage for psychological and political trouble.

Care practices and ethics thus work not to enable “choice and independence … care necessarily involves taking responsibility for recognizing what needs to be done for another” (Trnka & Trundle, 2014, 7; see also Held, 2006). Nested between human relationships, care is always an ongoing, dynamic, unstable and often unfinished process (Mol, 2008).

Anthropologists have shown that care can take may many forms, and that values of care always reflect wider cultural concerns, social hierarchies, notions of morality, and ideas of personhood. Care work is thus often deeply constitutive of the identities of both the carer and the cared for, revealing the types of dependencies, obligations and expectations that each must fill in their roles (see Buch, 2013). As care often involves unequal power relations, it has the ability to grant or negate agency in a range of ways. Care is a useful object of analysis in relation to children’s agency in Namibia because contemporary care practices seem to deny children’s agency, at the same time as they grant them much power over others and their wellbeing. Here we see the limits of understanding agency as solely being about choice, as the children have very little choice in caring for their relatives. Yet through their roles as carers they become full moral persons with high levels of responsibility for others, and it is through care work that they develop a morally positive sense of identity and come to value their cultural world.

Child labour debates

The two words *child* and *labour* combined in any dialogue or sentence nationally or internationally usually sound alarm bells. An article in a local newspaper, *The Namibian*, described how children in the far north-eastern part of Namibia are "robbed of their childhood" and forced to be adults (Tjihenuna, 2015). The article related to individual boys and girls between the ages of ten and thirteen who looked after their dying parents, providing care by feeding them, washing, cooking and cleaning. A comment by a reader (Kavetu, 2015) on that same article stated:

> I disagree with some aspects of your report, which terribly exaggerates the role of children. It seems a child of eleven cannot fetch water from an outside tap than you journalists complain that it is child labour. Similarly a child cannot take out the goats from the pens than you guys complain of bonded child labor.

This comment made by the reader is one of many divided opinions about child labour in Namibia which is often presented in terms of children being robbed of their childhood.

Anthropologists have long been involved in debates about child labour. Nieuwenhuys (1990; 1994; 2004), a leading theorist in child labour with her work amongst children in India, argues that a general perception exists in society, academia and policy worlds that children cannot play any part in the 'production of value' and are categorically not expected to form any part of the labour force. Child labour is regarded as a step backwards in terms of a nation's progress and prosperity and as a sign of a country not developed and underperforming (Nieuwenhuys, 1994, 237). In such a context, children in developing countries often find themselves involved in labour which is unlawful, but nevertheless an important means of survival for them and their families (Abebe, 2007, 77; Invernizzi, 2003, 320). As the growing literature on child labour focuses particularly in Southern Africa, Levine (2013) further argued:

> At a time when the terrain underneath anthropology is moving towards models of entanglement and congestion, where discord, complexity and ambiguity drive social theory, the field of child labour studies remains constrained by the moral tendencies that inhere in the subject of child labour. Caught up in taking sides over whether children's work is beneficial or harmful, child labour theorists tend

> to miss the complex ways in which children interweave descriptions of harm and benefits (2013, 12).

In this chapter I thus take up the challenge offered by Levine (2013), Nieuwenhuys (1994), Abebe (2007) and Invernizzi (2003), all of whom appeal for a broader understanding of child labour that is centred on children's viewpoints. The dilemma of child labour, especially in the rural areas of Namibia, centres on what practices children themselves experience as unfair and manipulative and the kind of work that children, caregivers and members of the community see as part of maturation, childhood socialisation and children's contribution to livelihoods.[59]

In this chapter I argue that we need to investigate how childhood features within systems of collective support in the Aaumbo community as it adapts to the current HIV/AIDS crisis. It is important to note that I am not trying to solve debates that critique or defend traditional cultural practices, but instead argue that local understandings of childhood are constantly changing. Furthermore, I reveal how public and urban imaginings of childhood, influenced by international discourse on children's rights and fuelled by the national media's stance in regard to how children ought to be allowed to strive in a post independent society, do not adequately account for children's own perspectives, agency and daily circumstances. I also contribute to debates about child labour, which tend to focus on children's work in economic spheres outside the home, by focusing on how care labour is understood within the domestic sphere. Just as care labour is made economically invisible within western capitalist society, the child labour debate within the international development and human rights worlds tends to reflect this bias, seeing exploitation in mines, fields, factories and plantations. But, in Namibia, concern centres on the domestic workload that children bear, and this has been exacerbated by concerns about the effects of illness on family structures.

[59] Abebe (2007, 82), noted children's "productive and domestic works within the household constitute the core of social reproduction in rural areas" and, as a result, "children's labour is not only vital in economic terms; it also comes to the fore in the continuation of societal systems themselves." This contribution to the continuation of societal systems can be seen in the cases of the four orphans in rural northern Namibia highlighted during my ethnographical research and it a topic which is largely ignored and underrated and about which almost no research has been conducted. The research also furthers the divisive debates in local and international media about what type of work children ought to do and their right to schooling (Ansell, 2005; Nieuwenhuys, 2005).

Research by Morten Skovdal (2010) in Western Kenya shows that extended families benefitted significantly by taking in orphans, who provided care and contributed to the household by generating extra income, taking care of younger children and, in many cases, also the elderly and the sick. He further argued that there is a need to re-examine the term 'caregiver', focusing not solely on family members who are legally or socially responsible for providing care to orphans in their homes, and to look at the interchange and exchanges of care that have developed whereby orphans also take care of their adopted households.
Thus orphans' care labour within extended households has remained fairly politically and socially invisible. This chapter aims to make such care work more visible. From a western perspective, and from the perspective of international development programmes, children in Namibia would likely be viewed as overburdened with domestic tasks that should be performed by adults. For most groups in Namibia, however, and especially among the Aaumbo, childhood is seen as a period where children contribute significantly to the household (Amathila, 2012; Namhila, 1997; Williams, 1991; Akawa, 2014).

"Care is me and I became care"

All around the village I would see older children carrying smaller siblings and supporting older people as they walked around. During my various discussions with these children, all of them had clear ideas about their roles in the household. None of them at any given time framed this work as a 'burden' on them. They were playing their part in a type of generalised reciprocity. Others in the household had been cared for by their grandparents before the grandparents became fragile. They thus expressed a reciprocal customary duty. Such a duty is commonplace in Namibia. As a northern Namibian tribe, the Kwanyama, commonly say, "*Kahuhwena hadela nyoko, nyoko onale ekuhadela*" (Kalomo, 2015, 13). "We have to help our elders because they have helped us."

My participants further constantly expressed their hope that somebody would look after them when they become old. As one young participant said, "If I care about my family now, then somebody will look after me one day when I get sick or old." They also saw this as valuable at a wider societal level, and as one participant explained, "Everybody in my homestead and around here [the neighbourhood and village] I regard as family and I love

them because God loves us all." The children never complained about their care responsibilities to me or directly asked me for any help in carrying out their duties. Any assistance I gave, such as taking them to see a sick relative, giving them a ride or taking them home, were all gestures initiated from my side. Recognising their commitment and acceptance of their duties does not act to "romanticize" these practices (Dagapioso, 2001, 91). As Dagapioso explains, in relation to Filipino street children, we can both recognise how certain practices might have a negative impact on children's current and future opportunities, at the same time that we acknowledge and pay attention to the decisions children make in their lives and the reasons children give for the sense of meaning their actions give their lives.

During the first days of my arrival at the primary school, which was followed by six weeks of voluntary teaching, I met the calm, helpful girl named Nangy. During the lunch breaks, I chose to sit outside amongst the learners. It was Nangy that came to sit next to me and took me on my first walk around the school showing me around the sandy, dusty playground. She was eleven years old at the time I met her, and tall and thin, but did not look more than nine years old. She was always neatly dressed in her school uniform which looked far too big for her body and her arm muscles were visible through the sleeves of her worn out white school blouse, rolled up at the ends to hide the torn material. During the break her younger siblings would all gather around her and she would provide them with the odd Aaumbo bread, *oshikwiila,* breaking this thick sweet bread made on the open fire into small pieces until there was almost none left for her. At the time I met Nangy I had no idea of the extent of her care work ethic, and during the first six weeks at school I complimented her on her active caring towards her younger siblings. She jokingly replied, with a soft tone of voice in my ear, "Care is me and I became care."

One morning as I was driving to the school, still six kilometres away, I spotted Nangy running with her heavy schoolbag across the field. I immediately stopped and offered her a ride. She was almost out of breath and sweaty and very thankful that I had stopped. She immediately expressed her concern that she was late for school. I assured that we would be at school in a few minutes and she needed to relax by putting her schoolbag on the floor and enjoying the

ride. As much as I wanted to assure her that we were just a few minutes away, she still looked worried.

After a few weeks of my being at the primary school, Nangy had become comfortable with spending lunch breaks with me and told me that she had lived with her grandmother since before she went to school. She also lived with three other younger siblings and had older siblings who currently lived with other family members. She would also talk about a few other family members who occasionally came from town. As she would say, “they came just to rest.” In further conversations, I came to learn that the word “rest” meant that these relatives, mainly aunts and uncles, came to die from illness. During further conversations, she explained that she initially lived with both her parents but her father died first, followed by her mother, leaving her and her siblings to move to her grandmother’s homestead.
Nangy would talk at length about the time they came to live with her grandmother and these conversations would overshadow any talk about her life with her parents.

During my home visits she waited anxiously and excitedly in front of their homestead and the first person I was introduced to, was her grandmother. Her grandmother was a frail and friendly woman, and at first glance I thought she was blind. But she explained to me touchingly that she needed to wait for an eye operation because she could not see properly any more. As Nangy showed me around their homestead, she proudly explained where everybody slept. There were four huts and her grandmother and a younger sibling slept together and she and two of her other siblings slept together. Nangy indicated to me that the other huts were for guests and for her grandmother’s daughters, who would occasionally visit and bring them some medication and food from town. Nangy also indicated that at times when their aunts did not come, their grandmother would provide for the family with money that she collected every month (referring to the state allowance given to pensioners in Namibia). Nangy proudly showed me the small tomato plants she was busy planting and explained how she had a love for growing vegetables, like potatoes and carrots. While I was at their homestead I never saw her uncle because those doors were always kept shut.

Coming back to our conversation in my pickup truck while we drove to school, Nangy told me that she was worried because her grandmother was becoming older and frailer each day and her uncle, who had returned from the city, was now also very sick. Her concern was not for herself, however, but centred on the wellbeing of both her grandmother and uncle. Nangy further explained that she was the one who had to do most of the caring, in the absence of other older family members working in the capital city, older siblings attending high schools in a different town or younger siblings who were too small. In this situation, she had to "become the stronger one and help and care for her household." During this conversation, she proudly and at length explained her daily duties which involved her seeing that everybody was fed and washed and, with regard to her uncle's daily care, mentioned making sure to give him medication before she went to school. After school her duties would normally be the same.

In my car, Nangy explained how that day she had needed to organise a taxi to take her uncle to the hospital because he had become weaker during the night. She then had to accompany him to the hospital in the taxi and was now trying to get back to school. She further explained that she had to go back to the hospital after school to see to his progress and condition because she needed to report upon her uncle's condition to her worried grandmother. Nangy could not remain with him while he stayed at the hospital because she needed to cook and to take care of her grandmother and younger siblings. She gently shrugged her tiny shoulders and continued to reaffirm in a softly spoken tone of voice,

> They are all my family and I cannot leave them, and my grandmother took care of us after my mother and father passed on and she is my responsibility, and my uncle is her blood and her son and I have to provide care for both of them because they are my family. Their care is important to me.

I was curious to know whether she found her daily responsibilities difficult, and how she divided her attention between caring for her family and her schoolwork. Nangy gave a brave smile and answered that she felt that school was very important and her grandmother expected her not to neglect going to school. However, she continuously stressed that she felt taking care of her family was also as important because "they are my family and one day

somebody will also take care of me when I get old." Despite these assurances that she balanced the two responsibilities, my observations revealed how she often had to miss school in order to care for her sick relatives, and after I left the field I heard that at the age of eleven she had stopped going to school altogether.

Caring and "new lungs"

On another occasion, during my home visit to the house of Messy, he constantly ran to a nearby hut taking water. His grandmother continually reminded him to close the door behind him before he sat down to have further discussions with me. I could hear somebody with a bad cough inside the adjacent hut. Messy did not reveal the purpose of his actions during my home visits but, during an individual conversation back at the school, while describing the functioning of the lungs in the body during our body mapping discussion, Messy spoke about his bedridden uncle. He explained his uncle continuously found it difficult to breathe. He jokingly and dramatically used his hands to cut across his body map in front of him. "Sometimes I want to cut his chest open and take out his lungs and put in new lungs, because I feel very sad and bad when he coughs and tries to breath." Messy revealed to me that he had looked after his uncle for more than a year, after he fell sick and could no longer work in the city. It was during this discussion that Messy revealed more about his caring duties and his daily care routine.

Messy proudly and confidently explained to me that he was the eldest of all his siblings and he had taken the care responsibility of his grandmother, sick uncle and younger siblings upon himself. When I asked him if he found it difficult to cope with school and having these care responsibilities, he jokingly said, "No, not at all. I won't die yet because I love my family." Yet the difficulty of juggling these two domains was evident in later conversations. He stated that his family was dependent on his help because there was nobody else who could do it. He added that because of this, he was sometimes late for school and would at times be absent for many days, but he felt that he loved them too much just to abandon them. I asked him why he felt his family was so important to him. He replied by saying,

> I think everybody's family is important and without my family, especially my grandmother, uncle, brothers and sisters, I would have nothing if they were not

there. I love my grandmother because she is old now and struggling to walk, but before that she took care even of my uncle who is sick.

Messy felt for him to abandon them all would be a bad reflection on his character, and he had also made a promise to his grandfather before his death that he would look after them and take care of his grandmother and other family members.

Messy proudly explained to me how his day would start by getting up very early and fetching some water to make porridge to feed the household. On the instruction of the doctors at the local hospital, it was important that his uncle had some porridge before he took his medication. Messy then explained that he was the one who accompanied his uncle to the local hospital to fetch his medication, and in most cases the doctor spoke to him and gave instructions to him with regards to the administration of the medication. He also made sure that enough porridge was left for his uncle and grandmother to have during the day until he returned in the afternoon.

At times during our discussions, I could see that this brave and caring boy became sad about the uncle he loved and he changed the topic to something less depressing. When he did talk about it he detailed how his uncle would often find it hard to breathe. “I sometimes stay with him during the night to make sure he will be okay, because my grandmother is too old to stay with him during the night.” He further explained that he also made sure that they had enough water, clean clothes and that their bedding had been washed. At night he would do some cooking and. with his smaller siblings, see that he collected enough wood for the following day. His last duties for the night would be to see that his uncle got his medication and then Messy would go to bed or sometimes fall asleep beside his uncle’s bed.

I asked him if he ever felt concerned and worried about his uncle and grandmother while he was at school, upon which he replied that both of them wanted him to go to school. He jokingly explained that sometimes when he felt it was necessary to stay at home to look after his family, his uncle and grandmother would chase him away to school. He felt that school was good to take his attention away from his family, and the few hours spent at school allowed him to play with his friends, as he hardly had time at home. Messy expressed

his desire to continue going to school because of his dream to become a nurse in the local hospital and to help as many sick people as he could. I was curious to know whether he received any help from other family members while taking care of his sickly uncle, siblings and grandmother, but Messy gave me a grim smile and answered, “No, it is very difficult. Other families have their own problems.” In the past, some of his other cousins came to help during the school holiday but they had to be around their own families who were also in need of care. He concluded, “Everybody is just on their own.” He proudly mentioned that he knew whatever he did his smaller siblings were constantly watching him, and when they grew up they would in turn help him when he got old. “This is how families are supposed to function,” he argued. “My family is my family, and I need to help whenever, wherever I can and I am very happy to do so because I regard it as my responsibility.”

Care also extended outside of the household into the biomedical sphere. I observed, during my time in the rural area, that family members accompanied patients to the hospital and, when they were admitted, in most cases remained around the patient while the patient stayed in the hospital. The person who accompanied the patient would provide care and support to the patient in the hospital in terms of providing extra food, seeing that the patient was washed, helping to get the patient in and out of bed, and if the patient was too weak, helping with the basics of feeding. Due to a shortage of staff, nurses and doctors would usually only oversee the administration of medication and treatments, measure vital signs, and diagnose illnesses. The overstretched resources in the home sphere were thus also extended to rural medical arenas, which relied upon the care work of children to function.

For both Nangy and Messy, they gained a sense of self-worth from being attentive and reliable carers within their families. Childhood was not understood as separable from other life stages, but was part of a broader cycle of kin reciprocity, as the elderly depended on children and, in turn, children would come to depend on others as they aged. Both children and those who depended upon them had to balance the heavy reliance of the sick on children, while also enabling time for children to forge their own future opportunities through education. Because resources were scarce, this balancing act was difficult to achieve, and children often struggled to cope.

Creating kin through care work

This chapter has shown that, through care, Messy and Nangy act as *alloparents* to their grandmothers and uncles and aunts. 'Alloparenting' refers to practices of parenting which are conducted by people other than the biological parents. The concept has been used to describe the care work that children receive, rather than give. Jill Brown (2011, 158), who explored how orphan children in Aaumbo households are cared for and the connection of those children to those particular families, noted that little research has dealt the significance of alloparents in these families. This chapter demonstrates further how, not only is there little research on the alloparenting *of* orphans, but that there is no research on alloparenting *by* orphans.

Recognising 'child alloparents' helps us to see children's agency in the wider kinship system. Children may take on alloparenting of non-biological patients who became 'family' through acts of care. This was apparent among my orphaned participants who looked after older and younger non-biologically related household members who through this care became like kin. While the literature on alloparenting shows how *performing* parental care work creates parental roles for adults, this chapter will show how *receiving* parental care work from children can also create parental type roles for those cared for by children. This was evident in the lives of Candy and Melody.

During one of my early visits to Candy and Melody, who were not related to each other or to their guardian 'aunt', I reached the maroela tree and couldn't see them sitting as they always did when doing their daily washing. We had agreed that we should always meet by this particular tree, as this area of the village had numerous unmarked houses with fewer than two to three metres between each of them, making it very difficult to distinguish one from another. The maroela tree served as a handy marker by which to find them. I saw Melody waving from one of the corrugated iron houses, as she threw out water from a small washing bucket. She beckoned me over. As I got nearer to the entrance, Melody performed a short quick bow, putting her left arm under her right hand, as is the custom when greeting an older person. Almost out of breath, she said, "Good morning, *Meme*, could you please help us to pick my uncle so that we can move clean things under him?"

I entered a small, windowless room to see a floor covered with sand. It was dark and humid, the only light coming through the door. The smell in the room was a mixture of fresh soapy water and the heavy scent of a person with an open wound. It reminded me of the mixture of smells hanging in the hospital corridors I had visited the previous day. The girls instructed me to move behind the head of the bed and the two of them moved to near the old man's feet. At first I tried to avoid eye contact with the patient because, although I did not know him, I had not adhered to the everyday custom of greeting him before I came into the room.[60] I found it difficult and awkward at first to concentrate. As strange as I found the situation, I realised that the girls were coming to trust me and to invite me into these normally hidden domains of their daily life.

We managed to lift the patient wrapped in the bed sheets onto the ground. Candy quickly threw freshly washed blankets onto a thin and worn out mattress that was stretched out on a pile of bricks. Following the instructions of the girls, I then picked up the sides of the sheets to lift the patient onto the bed again. Candy was quick to gently tilt the patient's head and give him some water. He was almost unable to drink, but Candy patiently wiped off the water that dripped out of the sides of his mouth. She asked, "*Tate, natu kupe omeva natango?"* "Father, could we give you more water?" She then wiped his face again before putting his head back down on the mattress. The girls thanked me and quickly covered the man with another heavy, grey blanket. Melody bent down near his ear and quietly asked, "*Tate, nandi kufeko ekumbafa limwe?"* "Uncle, could I take one blanket away?" Checking

[60] It is important for me to firstly explain why I felt hugely awkwardness by referring to the traditional greeting in the Aaumbo culture. Greeting is a huge gesture and it is through greeting that you, as an individual. demonstrate that the person (or as many people as are around) is being appreciated and cared for. In order to demonstrate this, an individual shows a keen interest in greeting people, making a huge effort and taking the time to greet everybody in that particular room or area. Therefore, in the Aaumbo tradition, whenever any room is entered, the person that enters needs to initiate a greeting. You first look around to see if you see any elderly people and they must be greeted first. Even if there are more than ten or 50 people, all of them need to be greeted individually and deliberately. *Tatekulu* (grandfather), *memekulu* (grandmother), *meme* (mother) and *tate* (father) are the specific words used to address anyone older than you and the elderly and the words are just as important as the greeting gesture itself. Because of this tradition, I felt rude to not be able to greet the patient as I entered the room. This custom also a reminder of the remarkable work of the renowned work of Sjaak van der Geest (2015) in the Ghana, where he observed that greeting could extend for a full day, but for him it was not just about "reciprocity" and "respect" but also about the "beauty and tyranny of convention and social performance."

that he was comfortable, they repeated several times the phrase, "*Ohatu ka aluka natango tuku etele oikulya imwe natango.*" "We will come back and give you some food."

I continued to feel bad about not having greeting the man when I entered the room, so I made an extra effort to greet him, stretching out my right arm and, with my left arm touching my right elbow and with a quick bending of my knee as a female should do, and he gives me a nod as is customary for a male. I replied, "*Walelepo, tate.*" *"*Good morning, father." He was a very tall man, pale in colour, with his bare toes sticking out the end of the bed. He was extremely thin. He stretched one arm from under the heavy blankets and greeted me, but the only sound I heard was heavy breathing, wheezing, followed by coughing. I left the room.

The technique shown by Candy and Melody in the way they handled the patient revealed the knowledge and skill that they had acquired in their role as family carers. Lifting and handling his tall, light and almost lifeless body with gentle attention, I realised that he was not the first patient they must have attended. For orphans like Melody and Candy, daily life was punctuated with the small routines involved in these numerous procedures of care: washing sick bodies, cleaning patients' rooms, feeding them, and attending to their daily regimens of medication.

Candy looked at Melody and then cast her eyes to the ground and explained that their 'uncle' was getting smaller and lighter each day, making it easier to care for "them". I asked her why she said, "them". Melody took over the conversation. "They do not stay long." Before I could ask any more questions, the girls returned to their washing. Melody eventually added, "No, they die." Melody immediately asked me to go and buy them some washing powder in order to wash some of the bed sheets and clothing that had been removed during the morning. I could see the conversation was upsetting them so I went to buy the washing power from a nearby shop.

When I returned, I surprised them by opening a packet of their favourite sweets. As they were opening the sweet papers, Melody continues our conversation, saying, "We try our best just to keep our uncle comfortable and he is for now OK." Candy further explained, by

counting on her thin fingers, the time since he had come to live with them. “He arrived the year before, when it started to get cold,” referring to when the Namibian winters begin around April or May. She further explained that he came from Windhoek and that their aunt had requested they look after him. Digging her feet much deeper into the dust, she explained that the aunt, to whom they were not related, helped them to survive by providing them with a place to stay together, and providing them with food.

Melody and Candy’s situation reveals the centrality of care to alloparenting in families that are not based on biological ties. Care flows in many different directions. The aunt takes on the role of a parent to the girls, through her guardianship and in assisting the girls with their daily needs. At the same time, the girls take on parental responsibilities towards a range of the aunt’s sick relatives, for whom she herself cannot care. This situation starts to unravel the stability of any typical definition of a ‘parent’ within an anthropology of kinship.

In sharing this care work, the girls were able to create new families. They formed sibling bonds with each other, and gained aunts and uncles, maternal and paternal figures that resembled, in part, the families they used to have. Yet these created kin bonds were unstable and contingent. They were dependent on care work to continue. The aunt would only keep the two girls together because of the care team that they offered. The aunt remains a guardian only so long as the care she offers the girls week by week continues, and the aunt only continues to offer her guardianship based on the care labour that the girls contribute to her wider household. Thus while the girls take great pride in the work they do, their ongoing survival and residency together depends on them continually being good carers and earning their place within the aunt’s family.

Conclusion

Like the caregiver children studied by Morten Skovdal (2011, 264) in Kenya, in my study shifting understandings of “duty and service are materialised through the socialisation of children … and local understandings of childhood.” This chapter has revealed how essential care work is to the wellbeing and reproduction of family life in rural Namibia. This may seem a self-evident universal fact of kinship but, in this case, the essential care work flows as much from children to dependent adults as from adults to dependent children. For children,

care work felt particularly essential in families not based on biological ties, and their ongoing membership in such families depended on their ability to continually provide care labour. Care was the main gift that circulated within the economies of reciprocity that governed kinship practices.

Care was, however, not always an easy gift for children to provide, and sometimes competed with other expectations of childhood, namely schooling. Here the reproduction of the family in the present could conflict with the labour necessary to produce desired possible futures. Trying to balancing family care with attendance at school also gave children an acceptable way to juggle the demands of others with the desire for time of one's own, and to pair hard physical work with relaxing time with one's peers and friends. Ultimately this chapter challenges ideas about what a child and a parent are, and shows how illness and disease can challenge family norms and roles. While an outsider might see exploited children overburdened by work, which constrains their life opportunities, children see meaningful ways in which to contribute to their households, and actively integrate care into their individual and social identities.

CHAPTER EIGHT

New forms of relatedness among orphans: blood ties, shared experience, belonging and alienation among kin

Introduction

This chapter focuses on the complex, daily lived experiences of four of my young participants, Melody, Candy, Strongman and Ben, who lived with non-biologically related families in the village. I examine their responses to and experiences of "created and formed" kinship (Carsten, 1997), as well as their longing for relatedness. As highlighted in the previous chapter, these four children were central to the maintenance and wellbeing of their households and families, particularly in the contexts of migration and the effects of HIV. The two girls in this study looked after bedridden patients on a full time basis, performing the duties of 'nurses', and the two boys, Strongman and Ben, collected and sold wood and also ran errands for various neighbours and oversaw empty households in the absence of their owners.

Janet Carsten (1997, 23) argues that anthropology should refashion our understanding of kinship through a relational perspective, as a set of practices woven into the lives of people sharing and living lives together. She further argued that kinship is not a "lifeless and pre-given force" that comes into people's lives in a "mysterious" manner but it is established through friendships, exchanges and people's connections with each other through their everyday lives and the political, economic and social demands made upon them. I argue that such an analysis is needed in relation to the anthropology of health and illness, which refashions kinship in new ways as children seek to form ties with non-biological kin or return to those with whom they feel they belong. Although these children's lives were full of challenges and limited options resulting from the death and illness of their parents and grandparents, they also found ways of forging "created and formed" relationships outside the assumed realm of *aanegumbo* – blood ties – and developed numerous ways to care for themselves amidst difficult circumstances.

“We are not sisters but we are sisters now”

When I first met Melody, aged twelve, doing some washing under a tree, she looked much older than twelve, her skinny body, hidden within oversized adult clothes. She stretched her hand out to me, holding her left hand under her right elbow and greeted me with a quick bow as it is custom in the Aaumbo tradition. Her hands felt rough and hard, like somebody who had constantly worked with her hands in water or with hard, rough surfaces. At first her striking marbled eyes, hidden behind her dusty braided hair, did not make any eye contact. She seemed to be in charge of all the activities around the house. She spoke on behalf of Candy, who was eleven and also lived in the household, and who helped her with various chores during the day. She acted like a caring mother, protective and sharing in nature. Even if Candy had had enough food already, Melody first gave her half of what she had on her own plate.

At first, Melody talked to me in a careful and reluctant manner as if to a total stranger, but we gradually became close over the course of my fieldwork. “*Meme*, please meet my *omumwayina* [sister]”, Melody said, on the first day we met. Candy was a shy girl at first; however, as time progressed she also opened up and became the joker of our group. She looked very mature for her age and was tall and thinly built. Candy was very hardworking as she tackled household tasks, and usually sang while she was busy with her chores. On my asking who taught her the songs, she replied her mother and grandmother. She was very adept at avoiding questions about her mother and, at various moments, if she did not want to answer a question or felt uncomfortable, she would quickly direct me to help her with fetching some water, starting a fire or buying some essentials from the nearby *cuca* shop. She enjoyed the drawing and photo voice activity and was very emotional upon seeing herself in a photograph.

In the course of the following weeks, I obtained consent from Melody and Candy and their guardian, and began visiting them almost every day for five months. I realised that Melody and Candy were not biologically sisters and that they were not even distantly related. Despite this, they explained that, “We are not sisters but we are sisters now.” This reflects a common feature of the children’s daily experiences with changing kinship connections, due to the effects of health and illness. This kind of kinship is not formed, as described by

Erdmute Alber and colleagues, (2013, 1) out of the "physical act of birth" but rather through "social practices" that emerge in the wake of HIV/AIDS and the widespread loss of parents. In the context of significantly reduced biological ties, kinship emerged, as it did for Melody and Candy, through relationships of living together, sharing the same hardships, laughter and tears, sharing a daily workload, dreaming about futures together, and sharing meals.

As Carsten (1997) shows, siblingship is a type of "mutuality of being" in which people become "intrinsic to one another's existence", or what Marshall Sahlins (2011, 2) refers to as involving "mutual person(s) … [and] intersubjective belonging." For Candy and Melody, sisterhood became the most significant kinship bond in their lives. "We are sisters now because we eat, sleep and do everything together," they explained to me. Melody explained, "If Candy is sad, I am also sad, and if Candy is sick, I will pray for her to get well again." Candy continued, by adding, "We both have each other and this made us sisters and family because we spend the entire day together, doing our chores, playing, laughing and singing songs together." Melody joyfully explained, "Whatever happens to us, we will continue to stay together until we are very old." Candy immediately got up and gave Melody a big hug.

As Melody started her washing duties by putting water into an old bathtub and pouring in the washing powder, she put some of the foam bubbles on my face and some on Candy's face. Melody continued to talk and explained how lonely she had felt before the arrival of Candy. Melody got up and smeared another batch of foam bubbles in Candy's face before she explained that Candy's arrival made everything better and they became sisters to each other. More seriously now, Melody recounted how Candy got lost for a few days after her arrival, coming back from the *cuca* shop. Candy interrupted Melody's reminiscences and explained, "But, *Meme*, every house looked the same to me and that is why I got lost on the first day." Melody gave Candy a sad smile and, with a very sincere facial expression, explained the distress of that particular day, as she became anxious waiting for Candy to come back, and said, "I remember that I started to cry." In a whisper, Melody explained that she only felt better when she saw Candy come around the corner of a nearby house, and her tears on her cheek at that moment indicated that they had become sisters. Melody

looked at me and Candy as she touched her face and explained that she could still taste the saltiness of her tears of that particular day.

Carsten's (1997, 5) insight that people can build kin over time out of sharing substantive experiences together applies here. She describes how kinship can work as a process of "coercive incorporation", through which outsiders of diverse origins are transformed into kin who are thought of as essentially similar. Melody and Candy could not trace their genealogies back to any common kin, and had never known, heard of, or seen each other before. Living together, but not coming from the same distant family or village, was unusual in this area and under the kin terms in the northern part of Namibia amongst the Aaumbo tribe. Therefore, the relationship between Melody and Candy reflects transformations in the kinship system that allowed them to say, "*Meme*, we told you as you see it, we are sisters now and that is it, and the day we met each other we became sisters forever." They instantaneously gave each other a big smile and hug. The relationship between Melody and Candy reveals how kinship can to be built upon, as John Borneman (2001, 31) describes relatedness as "the process of caring and being cared for".

In this chapter, I will also share the experiences as narrated by two boys, Ben and Strongman, who lived in the same catchment but with two different non-kin families. For the two boys, it was much tougher than it was for the girls because they lived individually with non-kin families and struggled to feel at home in their new households. Ben was very tall and particularly neat and looked much older than twelve years old. He was always washing his hands and face after chopping wood or after any eating activity. He was very shy and cautious at our first meeting but, as the days progressed and once his guardian left, he started to talk more freely. He collected wood and was responsible for cooking for his guardian's children after they returned from school and were involved in chores. He loved dogs and looked after his neighbour's dog. He was quick to avoid questions related to his parents and told me he preferred to talk about his dogs. I went with him on his rounds, collecting and selling wood, to have a chance of more conversation with him. Ben continuously saved money for his other siblings who came to visit him when they were on school holidays. He carefully put aside some money before handing the day's earnings

from selling wood to his guardian. He found most of the participatory activities too difficult but enjoyed the photo voice activity and, always eager for ways to make money or to see a viable business opportunity, Ben jokingly told me he wanted to save some money for his own camera and sell the photos. He also had hopes and dreams of becoming a fisherman, but his biggest dream was to move back to live with his extended family.

Strongman came across as a very mature boy and he informed me he had never been in school. Upon revealing this, he quickly told me not to tell anybody else, and added that he thought he could learn much better things on his own. His skin was very dry and cracked from the sun and it made him look much older. With his usual quick wit, he told me, "*Meme*, I am eleven years old but will be eighteen soon." He was thinly built but tall. His clothes were old and tattered, with some parts of the material totally gone, leaving holes all over. He did not wear any shoes and his feet were always hidden in the sand. He chose the nickname Strongman because he showed me his 'big' muscles (although they were tiny to me) as he picked up a few heavy pieces of wood to demonstrate how strong he was. He had never known his father and was only told by his grandfather and some other people that his father had died in a car accident when coming up from the south where he worked. He spoke fondly about his mother and how she was the best, but she fell severely ill after his father's death. During our various conversations he told me he could count and, when he sold wood, nobody could fool him with money. He wanted to earn enough money to go to the capital city where he felt "business was booming" and earn more money. He was keen to admit that he had never held a pen in his hands, when I asked him if he wanted to draw.

He however enjoyed the photo voice activity.

Aaumbo, kinship and adoption

In the Aaumbo tradition, children who lose parents are firstly adopted by their wider kin, comprising their extended family – their biological aunts, uncles, sisters, brothers and grandparents – who are known to the children already because of short or long stays spent in various different extended family homes (Kalomo, 2015). According to Jan Kuhanen and colleagues (2008), child-fostering and orphanhood has historically been a common and

accepted practices across Africa.[61] In Namibia, it was not unusual for children to go and stay with their extended families, especially in times of financial or economic difficulties. In the Aaumbo culture, children are commonly 'exchanged', going to live with known kin. In some instances, the intention is to support newlyweds, in which circumstances children are regarded as a gift and used for domestic labour (Nakale, 2006). In other instances, such as where a married woman was infertile, a child would also go to such a household and be raised as that family's own. Girls might also be sent to an aunt when puberty started to receive guidance about how to cook or learn to look after children in preparation for marriage (Brown, 2011; McKittrick, 1995).

I observed a range of ways in which children today continued to circulate within and across Aaumbo family groups. Within my homestay family, *Kuku* (the grandmother) was supported by her grandchildren, who would go to school in the local village and help with mainly domestic chores, taking the grandmother to the local clinic and hospital, feeding her if she was bedridden, herding the animals and helping in the field during the harvesting period. These school children would leave during the school holiday period, returning to their biological parents and making way for other grandchildren to come and attend to the grandmother's needs. When the school holidays ended, the grandchildren attending the local primary school would return and continue their schooling and other domestic duties. During a conversation with my host mother, she indicated to me that such arrangements kept the grandchildren "close to their culture". *Kuku* told me she felt that in the city the children lost track of their culture, particularly in terms of not knowing what hard work was all about. *Kuku* further stressed that, "They are under no obligation in the city to go and fetch water, collect wood and their time is divided into sleeping and eating." She also felt that children would be reconnected with their ancestors through the stories being told around the *olupale* (the hearth area in the homestead reserved for stories to be told) by the elderly men of the village, a practice they believed had been lost in the social life of the city. The concerns raised by *Kuku* relating to the maintenance of the Aaumbo culture are not highlighted in research of the Aaumbo, and in many cases such research only focuses on the

[61] The work of anthropologists, LeVine and colleagues (1994), is some of the earliest research giving a description of child care and rearing practices in Africa. See also the work of Weisner, Bradley and Kilbride (1997) and Caldwell (1997) on the complex systems through which children circulate amongst African families.

burden of grandchildren and grandparents on each other (Kalomo, 2015; Edwards-Jauch, 2009). However, as seen throughout my research, cultural and economic modes of reciprocity were central to the ongoing relevance of these kinship practices, a theme discussed throughout the narratives of the other 22 participants of my study.

Lucy Edwards-Jauch (2013) explained that historically children and woman played an essential role in the maintenance of agricultural activities in Namibia as part of the labour force. Children therefore became a "source of social security for the aged" (62). In the absence of institutionalised, government-funded systems of care for the elderly, this system that circulated children and their labour provided a vital informal means of supporting older people and their households, and of supporting those children who had lost their parents through death or illness. According to Jill Brown (2009), the four northern parts (Ohangwena, Omusati, Oshana and Oshikoto) of Namibia, where the Aaumbo people reside, have the highest rate of children who do not reside with their biological parents irrespective of whether their parents are still alive: children in the north who do not live with their biological parents range from 29.4 per cent to 36.9 per cent because of the various arrangements and child distribution systems. This means that children not living with their parents are not necessarily orphans, as they are commonly portrayed in academic literature.

In Aaumbo kinship terms, female and male cousins are all regarded as sister and brothers. There is no distinction between parallel or cross-cousins. According to Hayes and colleagues (1998), who studied mobility in Namibia and South Africa, kinship systems play a vital role in Namibian society particularly when it comes to child nurturing, in which families saw it as their responsibility, "almost without limits" (van Dijk & van Driel, 2009), to incorporate children in need.[62] Jill Brown (2013), in her studies amongst woman in the Aaumbo tribe who are part of these complex social distribution systems where children are circulated amongst family members, argued that how children survived and lived through these challenges and changes is still hugely under-researched in Namibia, while the focus has been mainly on fosterage. This chapter hopes to address this gap.

[62] See the work of Peletz (2001), dealing with the challenges these kinship arrangements create and, in the African context, see van Dijk & van Driel (2009) and Notermans (2008).

The Aaumbo people practise matrilineal descent. Men in the Aaumbo tradition do not pass on their matrilineal membership to children and the mother's brother is often responsible for taking care of children, in terms of fosterage and arranging care.[63] In the past, the husband's matrilineal family would come and take all his possessions from his wife after his death. However, recent laws make widows the primary caretaker of their children (Gordon, 2005) and, with the rising number of orphans, it has become necessary for both paternal and maternal kin to raise children. It is also becoming more commonplace for children to be born outside marriage and raised by single parents, which makes them particularly vulnerable and in need of extended kin support should their sole parent get sick or die (Kalomo, 2015).

The situation of orphans in Namibia

The 2013 *Namibian Demographic & Health Survey* indicated that fourteen per cent of children under the age of 18 in Namibia are orphaned, meaning one or both parents are death (MoHSS & ICF International, 2014, 21). The same report further stated that there was a huge increase in the percentage of orphans, with four per cent among children under five and 27 per cent among children aged fifteen to seventeen, with rural children more at risk of being orphaned than urban children. In many cases, the extended family becomes the safety net, but current research has shown that children are now also residing outside the assumed extended family networks. According to the Namibia Statistics Agency (2012), there has been an increase in the number of orphaned and vulnerable children from 150,589 in 2011 to 153,745 in 2014. The northern region has been reported to have the highest number of orphans and vulnerable children. For the Ohangwena region, there has been a decrease in orphans from 27,245 in 2011 to 24,594 in 2014, likely caused at least in part by the impact of ARV medication. Of my 26 participants, twenty children resided with their grandmothers, one resided with his biological mother, four resided with non-related guardians and one with a caregiver in the absence of her mother and father who were

[63] This is signified upon the death of the male in a household, when his inheritance will be inherited by his eldest brother. If no elder brother is alive, the inheritance will go to his elder sister's eldest son, followed by the eldest son of any of his sister's daughters. If the man has no other brothers or sisters, his inheritance will go to the eldest living person in the family of his mother's sister. When women die, her children will be in line to receive her inheritance, with the sons being given the cattle and the daughters receiving her jewellery and ornaments (Lebert, 2005).

working in mines in the southern part of the country. In a conversation with the guardian of Melody and Candy, she explained the reason why the two girls ended up her car, “We are all overburdened by our own family members’ children and then there are now many cases like Melody and Candy who have nowhere to go and nobody to go to and also need help.” Her reflection revealed that the fluidity that existed in the composition of extended families has become over-extended, yet families still continue to take on individuals who are in dire need (Crewe, 2002, 451).[64]

Urban and rural flows

All areas of northern Namibia have communal land ownership, high levels of poverty and food insecurity aggravated by global warming and a lack of economic and social infrastructure. Pempelani Mufune (2011) noted, as I also observed during my fieldwork, that the northern parts of Namibia, and specifically the region where my study took place, are mostly occupied by children and the elderly (Neingo, 2012; Haihambo et al., 2006) Edwards-Jauch (2009, 215) noted that children are not just left when parents have died but added that the cost of raising children in rural areas in terms of schooling, food and housing is much cheaper than in urban areas, which leads to parents sending their children to live with grandparents. She further argued that in the past children were given to the grandparents if both parents had died and the bride wealth would have been sufficient to sustain the maternal grandmother. However, as more children are born outside marriage, they circulate with fewer formally recognised resources. For the four orphans discussed in this chapter, their grandparents got too old to look after them, and other non-kin members of the village took them in.

[64] The living conditions and experiences of orphans have been investigated by Mienke van der Brug (2007, 87) during her ethnographical study with orphans in northern Namibia. She stated that orphans who stayed with their matrilineal families were treated much better, but she also observed that even those children were mistreated, continuously experiencing a heavy workload and verbal abuse. She further noted that female orphans had many responsibilities in terms of household chores and the orphans explained to her that they had hardly any free time. The same harsh treatment was also reported in a recent study (Mushaandja & Ashton, 2013) of the challenges orphans face within the context of HIV, food security and migration in the urban part of Namibia, Katutura. Orphans interviewed revealed that they were treated like slaves, sexually abused and in most cases beaten by their caregivers. Both these studies of orphans in Namibia did not look at orphans who resided outside the boundaries of their biological families or with distant family members, but both studies mentioned the huge burden orphans placed on family structures where families were already struggling to provide for their own members.

Most of the northern areas of Namibia depend on subsistence farming and agriculture and global warming has taken its toll on most of the rural agricultural areas. This is particularly true in the northern part of Namibia, where extreme weather patterns of flooding and drought have in recent years made maintenance of sustainable livelihoods increasingly difficult, and people, especially the young, have been moving to urban areas in search of employment (Angula, 2010; L. Brown, 2009; Reid at al., 2007; Reijer, 2013). This leaves rural areas vulnerable in terms of farm labour and food security. Such changes were evident during my fieldwork, as I drove past locked-up houses and barren fields. These wider circumstances place an even greater burden on children living with their grandparents to help during the harvesting period, and most of the elderly to whom I spoke talked about how their harvests had become considerably smaller and, in most cases, they were increasingly dependent on drought support from the government.

***Kuku* – the pride of the village**

During my fieldwork, almost all of the children were proud to tell me about the elderly lady in their village who was reputed to be aged over 104 years. I was curious to see her myself and one day on my way to my homestead I saw the elderly lady working in the *mahangu* field, busy ploughing. I stopped, greeted her politely and asked if I could assist to pick up the *mahangu*. *Kuku* looked up with her eyes in the sun and, after carefully studying me, she answered, “No, no, you are a stranger in my village and our guest and I cannot let you do my work.” I wanted to know if the *mahangu* season went well. After a long silence, while picking up the *mahangu* herself, she replied softly, “No, this year it was very dry. We had good rains last year.” She further added, “I do not know, some years we have too much rain [referring to the floods experienced in the country the previous year] and other years nothing, and God is punishing us.” I asked if she had any help during the harvesting period and she answered, “My sons and daughters all left to go to the city but my grandchildren are around to help after school.” *Kuku* further explained, “The city is good and not good, and sometimes they come back from the city and die and I do not know what happens there but [silence] … I am getting tired but need to eat and feed my grandchildren.” I tried again
to offer my help but she still refused and told me, “No, it’s fine, once we had more help from family and neighbours, but now it gets less and so many people are going to the city

and children need to go to school." I was curious to know if she thought that school was important for children.

> I did not go to school and I am fine but, these days, life is changing and children need to go to school because life is expensive and changing and they need to learn more so as not to struggle. But children also do not want to work in the fields anymore and run away and have many reasons for not wanting to work in the fields. When I was younger we had no choice. Had no school, worked in the homestead and in the fields every day, all day but [shaking her head] things have changed.

I wanted to know what she meant when she said life has changed. For some moments *Kuku* paused and looked at me with her eyes almost closed, with her hands shading her eyes to keep the sun away. "There are not so many coming home any more. If they do come home, they are sick." She looked into the distance. "And sometimes it is just difficult with the new weather coming and going." I wanted to know from her how many children she had herself and this brought a happy and sad smile to her face. She looked down and counted on her fingers and showed me: six sons and five daughters. "Wow! *Kuku*, that is a lot and you are blessed." She gave me a big smile and I noticed she had almost no teeth left in her mouth. "And how many still visit you?", I asked. "I only see four now (counting again on her fingers) because all the others are gone." *Kuku* started to gather her things and got up from the ground and, farewelling me politely, she walked into her hut.

This interaction reveals the dedication, even when it causes hardship, of the grandmothers to ensure that the devastation caused by AIDS that has impacted on their children does not destroy the lives of their grandchildren. School was a clear strategy to prevent the harm of illness travelling through the generations.[65] Without their grandmother's support, or the support of any biological kin, Melody, Candy, Strongman and Ben had a much harder time than the other orphans. In particular, they did not attend school, and their guardians did not

[65] See also the study of Daniël Reijer (2013) in the Copperbelt Province of Zambia, where grandparents must act as parents as they are left with their grandchildren, whose parents have died of HIV/AIDS.

see it as their responsibility to ensure they received an education. Support was limited to the maintenance of their bare necessities, rather than encouraging their flourishing.

Okwaandako [index finger] promises: trust, confidentiality and privacy demanded by participants

On one of the many days, as I made my way to Candy and Melody's place, I crossed paths with their guardian as she drove past me. She waved to me to stop, seemingly in a hurry. While other work colleagues waited in her car, she quickly to greet me and requested me to deliver a few food items to the girls. She was very eager to show what she had bought and opened all three bags, presumably to give me and her colleagues the impression that there was no neglect. She said, "Here you are, please give greetings to my girls and let them eat well." With a smile, she continued, and said, "I know these food items will be finished soon and I will see them again in a day or two with another delivery." These words brought smiles to the faces of her colleagues, as she proudly drove off. I arrived with the rations of food that consisted of maize meal, dry soup packets, tea and sugar. On my arrival, the girls were happy to help with the food bags. They thanked me, and their facial expressions suggested they thought the items came from me. I was quick to explain that their aunt had been in a hurry and so had asked me to deliver the bags.

For the first time, Melody showed a little aggression towards me and whispered to Candy, but I was unable to hear what she told her. I was at first unaware of the mounting tension, but later realised that they had not involved me (as they usually did) in any of their normal chores. As much as I tried to make small talk, the girls became more distant. All the usual help I would offer, such as fetching water or helping with their daily washing loads, Melody instead instructed Candy to do. Melody continuously told me, "*Ahowe, ahowe, Meme, ohandi shiningi*." "No, no, *Meme*, Candy can do it." "*Fyee otuli nawa oilonga ohatui longo*." "We are fine. You can just sit and we will do the work." As she said this, she avoided any eye contact. After a while, I realised that they still had not taken the three bags of food to their room or unpacked them. Unaware of what the girls were thinking, I asked, "Are you not going to unpack anything?" They looked at me and ignored me again, until Candy jumped up and, with a cheeky bounce as she ran away, said, "*Ngeenge owe shimono ndele topopi namene mumwaina wameme ngaho owe shikufa kumwe*." "You got it and spoke to our

aunt, then you unpack it." Her voice travelled in such a way that it made it hard not to hear. She quickly took the bags and ran off to their room and I left the girls not knowing what I had done wrong.

As Carsten argues (1997, 5), with regard to her own experience in the field, "fieldwork is a complex process of interaction". During my time in the field, I tried to reduce the distance between myself and the children involved in my research as much as possible. As much as they perceived me as an adult to be breaking down this barrier, it seemed at times nearly impossible. I tried to stay in the village and to remain visible and during the daytime I would help Melody, Candy, Strongman and Ben with as much of their daily workload as possible, instead of just being an observer. I would engage in washing clothes, sharing a meal, and fetching items from the nearby *cuca* shop. In this way, my relationship opened up areas of their lives that I would never have experienced in any other way. At first the children would find it difficult to accommodate me in such a way because they were accustomed to taking instructions from adults but unused to working alongside an adult. Strongman would say, "*Meme*, you are funny. I did not think a *meme* could help me to look for wood because I am always shouted at to go and look for wood on my own." Candy and Melody would at times accept my help, but whenever their guardian was around it was impossible for me to perform any task. When I discussed this with them, Melody responded, "We will be regarded as lazy because we have never worked with an adult but only taken instructions for chores we need to complete for them." From early on in the field, I gave all of the children their space when I felt they did not want me around or simply had had enough discussion for the day. In such instances, the social distance between adults and children became apparent and was difficult to overcome.

Coming back to the anger displayed by Melody and Candy, I was puzzled as I drove away, not knowing what I had done wrong. The next day I was not greeted with the normal happiness and eagerness to which I had become accustomed. They did not run to greet me but just sat and waited for me to join them, upon which I was greeted. I was determined to know what their concerns were and what had made them uneasy and upset. As I settled in, sitting in my normal place, Candy whispered in her usual joking way, "*Ame onda kumwa kutya omolwashike etu etlela paife natango yee eke shipopyeko kumeme."* "I wonder what

she has brought us this time and what she gossiped about with the *meme.*" She put her hands in front of her mouth, as she started to give a grim smile. I immediately became aware of why they had become distant and I got up and went back to my truck to fetch a few things that I had forgotten. Candy spontaneously followed me and told me, "We are not angry with you, *Meme*, we are just worried that you spoke to our aunt about our conversations. You also helping us and we are worried that she will be angry with us." "*Ito kala moo mu fiyo alushe fyee inatu hala oupyakadi washa*." *"*You will not be here forever and we do not want any trouble." I was deeply apologetic and reminded her of the first week we had met and asked her a question as a reminder, "Do you remember Melody's concerns about how we would need to keep all of our conversations between ourselves?" I reminded her of how in the first week she had jumped up and placed her index finger on my mouth and then made the same gesture on her own and Melody's mouths, as a sign that anything we discussed would become a secret, confidential and not to be told to her aunt. It was later confirmed by the children of the family with whom I resided that placing the index finger on the mouth is a typical gesture between children in the Aaumbo tradition, as it is in other places, if they want to keep anything a secret, spoken only amongst themselves.

Candy laughed and explained to Melody, "*Okwa fatulula kutya fyee itatu handukile meme kena fiku apopyesha kumeme mumwaina wameme shaashi okwe twaandako nale petameko*." "We cannot be angry at *Meme*. She will not tell 'aunt' anything because of the index finger promise we made." Melody smiled and all at once seemed to be her old self again. She immediately instructed me, "*Kwafelenge uye uka ete omeva nouleke nyee na*." *"Meme*, please go and fetch more water and sweets with Candy from the *cuca* shop."

Coping mechanisms, tactics and agency

Several issues arise from the vignettes above about the tension between the four children, their guardians and me in the field. Throughout my fieldwork, I learnt that the children, especially the four non-school attending orphans I worked with, did not trust and forgive easily. Their lives had been unsettled at a very young age: they had been taken from their families and placed with others outside the normal kinship system. With these huge adjustments and changing roles came forms of stigma and different relational challenges. All four of the children constantly related to the much happier times when they lived with their

grandparents after their parents passed on and when they were still living with all their other biological siblings before they were all placed with different families. The children would always refer to these “good times” in their life and became very distant whenever conversations around the death of their parents arose and would quickly change the subject to an unrelated discussion.

Trust was also hard to build and maintain as I was an outsider and also an adult that came from an unfamiliar place. Melody, Ben, Strongman and Candy always told me that they wished I could stay forever; however, they also knew that I would only be with them for a limited time. With lives riven with uncertainties and instabilities, coupled with constant fears and challenges, they realised that nothing would last forever, including their relationship with me and, irrespective of who passed their way, their lives continued. This meant that they were both aware of the temporary nature of our relationship, but were also able to live in the moment, appreciating what they had at any one time. During our times together, they thus continuously expressed their gratitude by giving me a hug, making and sharing a meal, an unexpected kiss on my cheek or, at many times, requesting me to remain longer and not leave.

Tensions with guardians

The anger the girls expressed towards me about my engagement with their guardian ‘aunt’ reflected the tense nature of that relationship. During my time spent with the girls, I would observe the strain between them and their guardian when they told me that she did not regularly provide groceries for them. She did not live with them, instead living in her own home a short distance away. The girls lived with a succession of bedridden adult patients for whom they cared. Without their aunt’s regular support, at times their only other option would have been to get food from the TB volunteers that brought along drought relief packages during their visits to the bedridden patients in the area, or food offered during the occasional festive event in the area would have helped to ease their hunger.

The girls wished to become nurses and also wanted to go to school, which furthermore created tensions with their aunt. As discussed, Aaumbo children do not normally challenge the behaviour of an adult. The fact that they were angry with me made sense because they

assumed any conversation I had with their guardian would expose their weaknesses, letting her know that they were hungry or needed basic essentials. On numerous occasions, I observed how they pretended to cope in front of their aunt, despite not having any food or soap with which to wash themselves. They would check her *ombepo* [literally wind, but used as a figure of speech to mean mood or frame of mind] when she visited them and assess whether or not she would be open to any requests. They were scared of her. Their main concern was being seen as a burden, which would result in them being moved on and separated. Most of all, they felt they had each other and that was the most important thing in making their lives bearable and happy, and they could not jeopardise that.

In exerting agency within a constrained social setting, Melody and Candy developed coping mechanisms as they carefully worked around the numerous challenges and restrictions they faced, in order to survive as 'sisters' and to remain together. I became one such strategy, as they talked to me about the possibility of going to school, asking me talk to their aunt about them going, and utilised me to get basic resources while I was there.

Strongman, trust and anger

The trust and confidentiality I built up were vital to my relationship with all the non-school attending orphans, and the responses from Melody and Candy described above were reflected in a similar angry reaction that I received from Strongman. One day, he angrily confronted me when I had waited for him to return from his errands. As he approached my pickup truck, he saw me having a short conversation with his guardian at the gate while I was waiting for him. As Strongman entered the gate he went straight to his shack and as I followed he mumbled, "*Meme, ino kundafana osho name. Ohand kaya diva nande oukale wemulombwela*." "Do not discuss me with *that* woman." Here he was referring to his guardian, to whom I had spoken to at the gate. "I will leave soon even if you tell her." I sat down and reaffirmed our initial agreements. I asked Strongman if I could read him a few notes out of my diary from our first few days together. Strongman started to hide his feet under the sand and, as he half-heartedly agreed, I opened my diary and started to read to him.

> Strongman moved his feet in the sand, and mumbled, "*Ovanhu ohava eta omandudakano ngeenge wevapopi ame omaudjuu ange okwa wana*." "People

> make a lot of trouble if you talk about them and I have enough trouble." He continued to shuffle his feet and made even more dust and I anxiously asked him what he meant. Strongman answered, "*Ame in ndihala nande oupyakadi washa naave*." "I really do not want any trouble for you." "*Ahowe meme hasho,ohandi tii ngeenge ondekulombwelesha otoi ndee to keshitya ko kovanhu ava?*" "No, *Meme*, no, not you. I mean if I should tell you something, will you go and tell these people?" He pointed in the direction of the people he lived with.
>
> "What do you think we should do, Strongman, because I can tell you now all our discussions will be safe? You chose the name Strongman and that is already telling you nobody knows that it is you." Strongman got nearer to me and reached out his right fist to me. I was surprised as he instructed me, "*Meme, ninga shafaafana ndele hatu tula omaoko etu kumwe*." "*Meme*, make the same and we will put our fists together." (Field diary entry, 2014).

As I closed my diary, Strongman started to laugh. "Yes, yes, *Meme*, I remember." He hid his face behind his hands, and as he faced me again, he continued, "*Ina ndihala nande uva lombelesha ondina okuya paif*." "I do not want you to tell them anything. I have to go soon."[66]

After these experiences, I made a firm decision to limit my discussions with any of the other family members of the four orphans. This meant that I did not come to understand in any depth the perspectives of orphan caregivers, and the account presented here is necessarily a partial, child-centred account. The orphans became central to my study and constantly and unconsciously reminded me of things I took for granted in the research, such as privacy, confidentiality and trust. Being an outsider and adult, these were issues I could not take for granted, but which needed to be continuously renegotiated and reaffirmed with my participants. My experiences made me aware that sometimes relationships between

[66] Similar situations to these were related to the work of van der Brug (2007, 34). In her study with orphans in Northern Namibia, she noted that trust was a fundamental component of research and the researcher needed to keep any promises made to their participants. Van der Brug further noted that in order to ensure that all discussions were kept confidential, the researcher needed to show a keen interest in what the participants had to say and be prepared to actively join in with activities, be wary of not becoming emotional involved and develop empathetic skills, to show willingness and compassion and be supportive in continuously reaffirming your interest in the people involved.

children and adults are not complementary, but may rather be antagonistic, and the ethnographer must choose one commitment at the expense of the other.[67]

Remembering past kinship

Despite being completely disconnected from all their kin, their memories of time with their previous families still structured the young participants' experiences of their current orphaned situation. Candy would specifically relate stories of her life at her own home, before the death of her parents and before her grandparents got too old to look after her, saying that that was the best time of her life. She would fondly gaze at the sky and excitedly ask, "*Meme*, *Meme*, come and look with me." With her long, thin fingers, she would point in the direction where she felt her village was located, "Can you see that? It is the direction of my village." She would excitedly describe the days when she had helped in the *mahangu* fields:

> *Meme*, even before the chickens woke, and that means earlier than usual, we would be up because we did not want the sun to catch us and everyone would lend a hand. The girls would hurry to get some wood and fetch water to make the early morning porridge before we all rushed off to the field. We would eat and go out and help with the planting, cultivating and harvesting, trying to get as much done as possible. We would be very proud if the storage bins [*eemanda*] place were full and, when they were, my grandfather and grandmother would praise us, each of the kids, for all the hard work.

Her recollection continued, as she explained that although it was very hard working constantly in the fields and around the house, it pleased her grandparents because it would give them great pride to see them all working together as a family and their ability to produce from the landholding of all their predecessors who had died long since. Candy would also smilingly relate anecdotes about chasing chickens when an unexpected guest arrived. It is a custom in the Aaumbo tradition to served cooked chicken with maroela oil (if

[67] The limited research conducted on children's lives in Namibia, for example Amakali (2013) and Kloppers (2000), has mostly involved understandings of children's experiences as interpreted by adults. Although children were part of these studies, they were not the main focus.

available) for a guest (Namhila, 1997). Candy would dramatically hold her nose high in the air, pretending to smell the aroma of the chicken covered with maroela oil; she would lick her dry hands and ask Melody to smell, too. She continued talking, explaining how her sister had taught her how to pluck chickens and prepare the meat, cooking it to perfection until she herself took over the role as she had become the best cook in the house. Candy would boast about all her cooking secrets and say that myself and Melody needed to pay her for her secrets, all of her best cooking tips, telling us, "I am keeping all my cooking secrets for my own daughters, *Meme*."

The girls would air their frustrations at not having any dried berries or spinach to eat, as it was difficult to get any in the area in which they were currently living. Melody remembered how they would eat too much, picking the fruit that fell from the trees, and sometimes be unable to eat any other meals. She said, with a big smile, "We had stomach-aches for days." Most of the fallen fruit and the spinach that had been planted would be dried for the winter seasons. Candy waved her arms in the air, demonstrating how the wind would gently separate the wheat from the chaff, and described how the chaff would become shiny and look like small butterflies going up into the air with the sunlight shining upon them.

Strongman also shared memories of his family with me, speaking fondly about the cattle of his grandfather and how he used to help to take them to the fields for grazing. He looked around the area and, with a sad smile, told me that he missed being in the field with the animals and explained that it would take him away from home very early in the morning and he would not return until sunset. Strongman proudly smiled, with his beautiful white teeth, and added, "I made my grandfather very proud, if all the animals returned and were accounted for." He would proudly boast of how he fooled the chickens early in the morning, chasing them away from their coop to get the eggs they laid, but only taking one or two eggs for his grandfather so the rest would be left to gain trust from the chickens that he did not intend to steal all of their eggs. According to Strongman, only taking two of the eggs instead of all of them would give him a better chance the next time he chased the chickens away from their coop. "They would go away more easily, without a struggle, which prevented me being attacked all the time." Strongman recalled that times that, while being in the field with the cattle, he would catch some fish after a heavy rainfall and proudly bring

it home to surprise his family. "*Meme*, we loved to eat the fish because it would mean that we could taste something different and the fish were only ever around in the rainy season." He smiled as he fondly recalled how his grandfather would praise him and tell him how great he would be and how he would follow in his footsteps, becoming a good man and providing for his own family. Strongman remembered his sisters making him food on his return from the field, which he now had to do for himself because there were no girls to sweep and cook where he lived. He proudly added, "Cooking made me become a good cook!" He invited me with a smile, "None of the children that I look after have died yet. *Meme*, you must come and taste my food." Strongman compared the school children left in his care, and who he fed after school, to his own brothers and sisters. Caring for them provided him comfort in the absence of his own biological brothers and sisters. He expressed his desire to look for work so that he could manage to support his brothers and sisters, so that eventually they could live together again. These memories were important to the children; they often evoked them to remember that life could be good. Their reflections and these memories provided them with a kind of cultural touchstone in thinking about their place in the world, and enabled them to continue living their lives irrespective of their current hardships.

Sometimes memories of the past could also be used to help the children see their current life as meaningful and perhaps even lucky. Melody said that the chores in and around the house in which they were currently living were much better than her those she had been required to do with her natal family, because they did not have the early morning rush to the fields. I had my own concerns and questioned the girls about whether they received any incentives for looking after all the sick and bedridden people in their new 'family'. For a brief moment both the girls gazed at each other, and Melody replied. "Yes, at times it is tough, however we are both grateful." Slowly folding Candy's hands in her own, she said "Because she took us in and gave us a new place." Candy interrupted, "Yes, Melody is correct to say she gave us a place when we had nobody of our own families left to look after us." Melody continued, "How can we then think of asking her for money? We think the little she can provide us with is OK and the rest we can sort out on our own." Melody looked at Candy and added, "We are big girls now." The girls outwardly showed huge respect for their guardian and saw their own caring responsibilities as "giving something back". When their

guardian came to the house during the day, while I was there, they would give her a full account of their activities for the day. They would report to her about the patient's condition, how much he coughed or any requests he made, and would inform her if the TB volunteers had visited and, if so, relay their specific instructions.

Both the girls sought to convey to me their loyalty to their guardian and to emphasise that they were obedient girls, as would have been expected had they still been living in the household with their biological families. Candy explained further, saying, "*Meme*, you must understand, somebody else will also take care of us when we become old and this is what we need to do in order to be sure somebody else will look after us." Melody referred to her grandmother, who looked after her mother and several other extended family members that were sick. She explained, "*Meme*, I feel it is expected that help is given and not to expect any money while caring for others means we are good girls and show respect for each other and the elderly. I feel my mother and grandmother would be very proud of us."

The loyalty of girls is a common cultural norm within Aaumbo society. A recent Namibian book, *Omona Wamukweni Eyoko,* (the title of which translates as "the ill treatment of an orphaned child who does not biologically belong to you and the burden that comes with that responsibility"), tells of the life of a very young girl who was severely mistreated by her aunt. However, the girl endured all the hardship and her loyalty, respect and sheer resilience led her to survive. This tale reveals a particular cultural script in regard to the expectations of gendered labour, responsibility and the rewards that underpin family life in much of Namibia. For both Melody and Candy, quite apart from their loyalty to their aunt, the memories of their own families before they became orphans shaped their expectations of family life, and helped to prepared them for the type of adult life as a woman they might expect in the future.

The need of orphans to foster social ties, in the face of stigma and isolation

Patricia Henderson (2006, 304), argues that double orphans in the Kwa-Zulu Natal region must continually recreate "both belongingness and survival." Her argument centres on how the media portrays orphans. The death of their parents, the media suggests, leads to their "social pathology". Without parental guidance, such a discourse suggests, orphans are

destined to engage in crime, remain poor, and become juvenile delinquents, and therefore have a bleak future. The portrayal of orphans in such a way makes them vulnerable to social isolation and stigma. In the case of these four of my orphaned young participants, they were also socially isolated because their guardians were cautious of taking them to the local clinic for fear of being asked questions about why they did not attend school.

Despite these forms of isolation, the non-school attending orphans formed various relationships in an effort to help support themselves. As explained by the four orphans, in the absence of a supportive extended family structure, they formed diverse and diffused relationships and these ties of reciprocity and obligation within the village community helped to ensure their own survival irrespective of their situation. For Melody and Candy, neighbourhood relationships helped them in various ways. Primarily, they bolstered their daily survival in terms of food security, but they also offered health education and exposure to school learning. On several occasions, the girls described being very hungry. Neighbours would visit infrequently, often coming to see the patients in the girls' care, and would leave them with extra food that the patients did not want. Neighbours would also ask them to look after their school-aged children. For this the girls often received money, and well as clothing and some extra food supplies. This particular relationship with the neighbouring school children gave them some insight into the school system and shaped their desire to go to school, as will be discussed next chapter. Melody and Candy would carefully watch how these children did their homework and from this learn themselves the basics of reading and writing. Thirdly, the girls formed relationships with the TB volunteers, which also will be discussed in more depth in the following chapter. These volunteers guided them, not only in how to care for their bed-ridden patients, but also by giving them health information for themselves. Moreover, the TB workers would sometimes give them drought relief food, which was on occasion distributed through the local clinics. This would ensure that the girls had much needed extra food.

Strongman and Ben regarded their relationships outside the place where they stayed as much better than that with their adopted family. Ben recounted to me the moment he fell ill one night, and was taken by the neighbour to the nearby clinic. "It is these people next door (pointing to the neighbours' hut) that helped me when I got hurt and without their

help I think I would have died." Ben further explained, "I look after their dog." He started to laugh. "It is just a dog but if they see I care for their dog, they also care for me. I also help them to wash their dishes and so they always see that I also get a plate of food which has saved me many times, so I do not go hungry. *Meme*, when they go to visit other family I feel lonely, but they leave the dog and some food and I am happy when they return." Strongman's bond with the people he had to run errands for ensured he gained many skills, and also at times, when he returned from the shops, some food. "These people saw that I was very hungry and gave me some *kapana* [fried meat from an open fire] which will last me for a few days. These people (referring to the people he lived with), they do not care that much. They are only interested in the money I can give them after selling wood."

Families of origin versus new 'families'

For the two boys, accepting and building new kinship bonds with people not biologically related to them proved extremely challenging. Ben felt a great degree of resentment towards his new family. During our time spent together and in his various conversations with me, Ben would continuously stress his deep desire to look for his father's family, which he regarded as his true family. The tensions Ben experienced with his guardian became particularly noticeable one day. As I drove towards Ben's house, he was engaged in a huge argument with his guardian. I was caught off guard by their raised voices, and didn't know how to react or what to do. Ben eagerly waved at me, insisting that we needed to stick to our agreed appointment. I could tell he wanted to get away from his guardian at that given moment. I was still a little rattled and felt awkward as his aunt greeted me and then quickly disappeared from the gate into the street. Instead of asking what the argument had been about, I opted to ask more about his family connection with the household in which he was residing. Ben and I eventually sat down away some distance from the house of his guardian but on the same premises. We settled down under a black plastic veranda on poles, which he had gathered from the rubbish pile which served as an entrance to his own makeshift room. He offered me a white chair without any legs, supported instead by pieces of wood left over from his chopping. As I placed myself on the chair, I noticed Ben had not calmed down. He tried to wash his hands and face with a cup of water and, as he angrily slapped the water in all directions, it splashed into my face. He was not the normal carefree boy I

had come to know. I attracted his attention by laughing as I tried to cover my face from the odd splashes of water coming my way, upon which he immediately stopped and apologised.

As I saw him still looking in the direction that his guardian had gone, I took the opportunity to ask him if she was related to his mother or father. Ben quickly jumped up and started to chop wood into smaller pieces and, after a brief silence, he abruptly answered, “She is nothing of me, not my family. I just came here and she took me in.” In making this statement, he used an expression - *omuyeni* - which means “stranger” in the Oshiwambo language. He was fuming, and pieces of the wood were flying all over the place. He picked some of the wood and, taking his place next to me, he tried his best to control his emotions. He further explained that he had been sent to the village by his grandmother, who felt she was getting too old to care for him. Ben told me that his grandmother had informed him that the house of his guardian was the place where his late mother’s sister lived and they would continue to take care of him. Without thinking I told him, “Now, Ben that means the person you had the argument with was your aunt.” Ben looked at me with a big quizzical frown and immediately replied “No, no, *Meme*.” He waved a finger at me firmly. “She is not my family. I came to the wrong house but then I stayed on.” I tried to apologise for my misunderstanding, but Ben interrupted me and explained that his mother’s sister had also died, and this was her house, which had been taken over by the guardian with whom he was currently residing. Ben got up and chopped more wood and I then got up and went to my truck to collect my breakfast box. Ben immediately followed me, being worried I was about to leave, but I explained that I wanted us to have some breakfast together. I shared some bread, fruit and juice with him. Somehow his usual glowing, happy face returned, and he gave me a big smile as we started to eat together. Moments like these, of strong emotional responses, revealed that orphaned children experienced ‘family life’ as entailing high degrees of precarity and marginalisation. Yet children like Ben have the ability to reflect upon this consciously, to decide for themselves who they call and regard as kin, and to feel that they have some agency in maintaining distance and independence from new ‘guardians’.

Conclusion

In this chapter, I have argued that in the middle of the HIV/AIDS epidemic kinship must be continually renegotiated and, for orphaned children, tactical kinship is essential for survival. Kinship ties can be replaced by friendships between orphans, neighbourly relations, and roles that resemble domestic labourers or maids within new households. Unlike the last chapter, where children lived with grandmothers and saw their labour as nested within ties of love, affection and multi-generational obligations, from the perspectives of orphaned children who reside with strangers, these new household arrangements are typified by uncertainty, fear, resentment and a lack of care. These children saw themselves as the casualties of Namibia's health challenges, in which families are destroyed by illness, and those who survive cannot easily find substitutes for family life. Living in a new household does not equate to finding a new family. Despite this, the children found ways to make their circumstances and current lives meaningful and to think how the limited opportunities afforded to them now might lead to better opportunities in the future. This is the subject of the final chapter, in which I show how the orphans built dreams, imagined better lives and used hope for the future to live in the present.

CHAPTER NINE

Hopeful childhoods: the art of survival and dreaming of the future

Introduction

As discussed in Chapter Eight, in global human rights discourse, child labour is often cast as representing the absence of agency. In this chapter, I argue that it was particularly through work strategies that my orphaned participants imagined a better future and worked towards improving their situations. Labour as a strategy of childhood agency is not a new phenomenon in the African context. Pamela Reynolds (1991), in her ethnography of labour amongst Tonga children in Zimbabwe, points out that through labour and various other strategies children are able to demonstrate a great deal of independence and cultivate support for each other. Reynolds concluded that, "We learn something of value about childhood if [we accept] that children partially negotiate their fate … Support is not given to all that fall within the sanctioned kin norms. The relationship is negotiated: the child's role is an active one" (143-144). In relation to anthropology's desire to reveal the unequal structures that constrain and shape life, as Heather Montgomery (2009, 12) argues, "it is important to remember that some children continue to hope, dream and work their way out of poverty or desperation in which they find themselves". In this chapter, I explore how the hopes and the dreams of the working orphans link pragmatic and constrained approaches to present circumstances to imagined future selves and opportunities. Disease and illness within the Village both enabled and truncated these hopes and dreams.

Girls' dreams: nursing and teaching

After helping Candy and Melody attend a bed-ridden man in their house, I was quick to compliment the girls as they came to join me under the tree. "You girls did so well today and you are actually nurses." Both girls started to laugh. "Are we really nurses?" they responded. Melody and Candy often expressed their desire to go to school and become professional nurses and they were delighted that I thought they were already skilled in this area. Such aspirations were visible when the girls discussed a previous patient in their care. Without making any eye contact, Candy kicked her feet deeper into the sand, and started to explain, "Before we used to look after another aunt and she also went to the hospital twice

but on the second time she did not return." As they settle down next to me, I pose a question by asking, "Did your aunt tell you what happened to her?" Melody and Candy both looked down and at first did not answer but eventually they continued speaking. Speaking softly, and holding their hands in front of their mouths as if they were gossiping, they looking around for any bystanders before they continued. Melody said, "No, but we heard from somebody else she had gone when they came to pick the blankets and things she had left here." As I looked at their facial expressions, it seemed too sad to continue any further with the conversation and I suggested we take a break and that I make arrangements to visit the hospital later. They were happy and stood close to me as I called their aunt on the phone and tried to convince her to let me take them to see the hospital.

Their guardian finally agreed to me showing them only the outside of the hospital building, upon which the girls jumped for joy as I gave them a thumbs up. They first ran to see if their patient had enough water and to inform him we were going out. Melody noted he was sleeping so suggested we hurry, to come back before he woke. Both girls were excited to see the outside of the hospital and, with all the traffic and people in front of the hospital and the nurses making their way home, Melody reaffirmed that she wanted to become a nurse. I reminded Melody of her experience of looking after sick people, which involved bathing them, giving them food, getting advice from the TB volunteers, and even telling her aunt and the TB ladies when she could see that the sick people were getting worse. "You are clever girls. See, you are nurses. How else could you think of what you are doing except as nurses?" Both girls had big smiles on their faces. Melody excitingly and proudly continued, "We also give them their medicine because it is very important to them."

Returning to the previous conversation, Candy explained that, "We only were told that she had died by the people who came to fetch her blankets and other small things." Complete silence entered the car, but Melody eventually said, "If I can become a nurse, I will see that nobody dies and everybody is cared for." She gently took Candy's hand as a comfort. As we took a break and went back home, Melody ran to the uncle's rooms to check on him. She returned with a white plastic bag, full of holes, and opened it. Sitting down, she moved closer to me, and explained, "*Meme*, see. Here is all the medication, some is from the TB ladies, and others are from my aunt that they brought from Windhoek." A closer look the

medication in the plastic bag revealed it was filled with TB medication, ARV medication and vitamins used to boost the immune system, which the labels of privately owned pharmacies indicated had been privately bought.

Candy was eager to explain as she took some of the medication out of the bigger bag and exclaimed, "*Meme*, *Meme*, can you see?" She showed me the plastic cover of the medication distributed by the local clinic and hospital, and indicated the graphics of a morning sun and setting sun going down at night time. Candy proudly remarked, "Me and Melody, we just follow that and mostly the TB ladies help us," and cheekily she added "and we help them." For Melody, looking after bed-ridden people gave her an opportunity to learn more about caring for the sick and she felt that the experience prepared her to become a nurse. She became very sad when she spoke about her mother and other relatives in her household that she had not been able to help. She felt that she could do more in the future if she could go to school and eventually have the opportunity to join the health profession as a nurse, as she hoped to "help others".

As Candy and I were chatting and playing a game, Melody interrupted and there was sudden urgency in her voice as she instructed Candy to get some firewood so she could prepare some food. Candy was quick to tell me, "It's my school children coming home and they will surely be hungry and therefore I need to prepare some food." She further explained, "No, no, *Meme*, you look worried, as we are not only nurses, we are also teachers and take care of a few children until their parents get home from work." She gave me no chance to ask but excitedly explained further that the children belonged to their neighbours and were like their own brothers and sisters. They were younger than Candy and Melody and their responsibility was to see that the children had something to eat and sometimes they also did some washing if their clothes were dirty, to be ready for the next morning. Candy explained that the parents rewarded the help by giving the girls extra food and a supply of clothes.

For the first time, Candy expressed her wish to become a teacher, which she related to her love for children. "I think, *Meme*, there are a lot of children here (turning my face in the direction of some children walking by) and there will always be a need for children to go to

school, and I will never be without a job or money because teachers are important." Candy and her dream of becoming a teacher, and Melody's dream of becoming a nurse highlighted their ability to think both within and outside of their own situations as orphans.

While not being able to go to school, they gained confidence and experience in jobs associated with their care work, and used this to imagine better lives for themselves and a means by which to overcome their precarious situations. Understanding their current situation as one which allowed them to build skills (rather than simply preventing them from attending school) helped them to be resilient in the face of hardship and constrained choices. Yet the girls' dreams were also shaped by the gendered possibilities that they saw for women in their own village and girls in their own circumstances, making these plans both pragmatic and aspirational, and demonstrating how children's dreams are both constrained and enabled by their social environment.

Entrepreneurial skills and dreams

Ben dreamed of leaving the rural area and going to become a fisherman in one of the country's biggest harbour towns. Strongman dreamed of becoming rich and joining the mining sector, moving from rural Ohangwena to Oranjemund in the southern part of the country. Such dreams have a long history in Namibia as pathways for economic survival, opportunity and even prosperity (Mufune, 2011; Moorsom, 1997; Tonjes, 1996). Most people living in Namibia's rural areas are drawn to the cities because of the lack of work opportunities and the scarce resources in rural areas, and the hopes for a better life in the city. A report on urbanisation in Namibia (Indongo, Angombe & Nickanor, 2013) revealed that people leave the rural areas primarily for employment, education or work transfers, a list regarded by Inge Tvedten (2004, 407) as the "push and pull factors" of poverty.[68]
Because most of the income generating opportunities, private and public funding, better health facilities and educational options are in the urban areas, the two-thirds of the

Namibian population who live in the rural areas, mostly in the four northern regions of the country, continue to migrate to urban cities (MoHSS & ICF International, 2014).

[68] See also the earlier work of Bruce Frayne (2005; 2007), one of only a few studies conducted on rural survival, migration and food security in Namibia.

As he was feeding his favourite stray dog some of the leftovers, Ben told me, without making any eye contact, “If I have enough money saved, then I want to leave.” He continued to outline his plan of how he would make this escape. He explained that his agreement with the family he lived with was that he was expected to bring them the money for the wood he sold. He scribbled in a patch of sand in front of us a few numbers. Ben looked suspiciously around, keeping his hands in front of his mouth, and whispered that he took part of the money to save. A satisfied smile spread across his face, and he further explained that the argument he had previously had with his guardian was because she demanded more money and, because he had not sold enough wood that particular morning and then kept the little he had earned for his own savings, his guardian was not happy.

For Ben and Strongman, accepting a new kinship bond with non-kin families proved to be very challenging and, unlike the girls, they ultimately resisted it. For both of them it meant constantly adjusting their tactics in response to their daily economic and social opportunities and constraints. Instead of simply being victims of the health and illness scenarios in which they found themselves, they acted as tactical agents who could weave opportunistic pathways through social constraints. I therefore want to adopt the metaphor of ‘navigation’ and, as suggested by Henrik Vigh (2006; 2009) with his work in Guinea Bissau, West Africa, taking the concept of navigation from the map and utilising it in the social arena as “social navigation”. As explained by Vigh, “we organise ourselves and act in relation to the interplay of the social forces and pressures that surround us, and that social navigation designates the practice of moving within a moving environment” (2009, 425). Both boys felt they had actively chosen to stay put and to create a space within which they could accumulate money, through selling wood and other income generating activities, in order to eventually move on. Both of them took huge risks by not declaring their full earnings to their guardians. They took these risks knowing that as a consequence they could be chased away or further abused by the heads of their households.

“I do not want to live with *omuyeni* [strangers]. I want to live with my father’s family, which is also my family, living in Walvis Bay,” Ben explained to me. I was shocked that he used the word *omuyeni* which, in the Oshiwambo language, is a strong word referring to a foreign person, and which clearly conveyed his sense of resentment and unrelatedness. The use of

the Aaumbo words *ovanhu uhevashi* instead would have meant that he had come to this homestead at a young age and, although they were once strangers, he now accepted them as his own family. Ben thus did not use this term. “Once I find my father’s family, I will feel I am with family.” For Ben, this signified the continued “web of inter-and intragenerational kinship relations” as described by Erdmute Alber’s (2013, 91) work on sibling relations in Benin. Alber argued that sibling relationships are as important as marriage ties in many parts of Africa. It was likewise important for Ben to maintain his relationship with his brothers and sisters, even if they stayed apart, and his persistent desire to find his father’s family also involved bringing the siblings all back together. Ben was thus putting away extra money for the time when his other siblings came to visit during school holidays.

The hardships and challenges were mostly of a similar level for all four of these orphans, but one of the four orphans demonstrated an impressive amount of sheer survival skill, a will to improvise and individual entrepreneurial skills, despite not being in school. When I met Strongman for the first time, he did not make any eye contact when his guardian introduced me to him. The ‘aunt’ immediately left us and it was only when I sat down that he looked up and talked to me. As he fondly spoke about his mother, his face changed and he said, “*Meme*, I have a heavy pain in my heart (he started to beat on his chest) because my grandfather died and it all changed.” He further said, “Now all of us (referring to his siblings) have to stay apart.” Strongman carefully put aside some money every day before handing the day’s earnings from selling wood to his guardian. On one occasion when I was present, I watched him take part of his daily earnings and wrap it in old newspaper. He was quick to ask me, “Please, please, *Meme*, do not tell anybody that I am taking part of the money for myself. I am doing this to support my other brothers and sisters who do not live with me but who visit me during the school holidays.”

Strongman added that he had his own way to count his money when he sold some wood, and laughed, when he whispered to me, “Nobody is able to rob or fool me, *Meme*.” He told me how his grandfather had taught him a few tricks and I was eager to hear about these tricks. He jokingly told me, “*Meme*, it is not good to reveal your tricks to everybody,” but, looking at me with a broad smile, he said, “*Meme*, I know you will leave soon and my secrets are safe with you.” We both had a great laugh. Strongman continued to show me his tricks

and carefully took out some old newspapers that he had gathered and told me, “I look first at the numbers (denominations) on the banknotes.” He came nearer and, with excitement, asked me, “Can you see, can you see?” Upon which he wrapped the money in the smaller newspaper pieces and continued to explain, “The number of paper wrappings will tell me how much money there is and the amount of the banknotes. This also helps me at night because it’s easier to count in the dark.” He laughed again when he told me, “A teacher would not be able to teach me what my grandfather taught me”, and he tried to convince me that he did not need any schooling.

On one occasion when I was about to leave, he was called to the gate and ran back asking me to take him to town to do some errands in the *cuca* shops in the area. I was somewhat curious to know how he would remember all the things he needed to buy without having a list. He explained to me that he made use of the rubbish dump to collect empty food packaging with its illustrations and tore it smaller to help him remember the items he needed to buy. He would also use this empty food packaging to relate to those serving in the shops and would constantly gather them and look for something particular in the food advertising in the same vein, once showing me a great lion on one of the food containers. He was proud to show me around the shop, giving all the money he had in his pockets to buy the items, and exclaiming, “*Meme*, I am a business man and will be rich and come back to my grandfather’s village as a village chief and be like my great-grandfather in helping others to become the best they can be.” He also told me of his struggles: sometimes having to walk long distances to get the right prices and carry heavy bags. “*Meme*, do you see my muscles? This is from all the heavy bags I carry and, the more I carry, the more money I can have.” He further boasted, “*Meme*, they [the small *cuca* shop owners] will miss me when I must go because I am reliable and do not take any extra money from them and I am as quick as the wind when they need their things in a hurry. I am grateful to you because now I have transport and I can do much more.”

The work of Abebe (2007; 2013), amongst children in coffee plantations in the Gedeo District, South Ethiopia, highlights children’s participation in trade activities. He noted that these children gained huge and valuable experience, developing their people skills and negotiation skills and building up relationships with adults, learning how to work and earn

money. He further argued that child labour activities cannot be separated from their "complex material realities" and the environments in which they live which revolve around trade and seasonal work for the children of Gedeo. The skills gained by Strongman in negotiating for the best prices made him gain experience in the commercial world on which he depended for his daily survival. In supplementing his income of selling wood and in generating more money for himself and siblings, he was able to plan for and imagine a time when he could to leave the village and be self-sufficient.

The two orphan 'entrepreneurs', Strongman and Ben, thus became part of the village cash economy. They took any opportunity they could get, be it their daily wood chopping activities, looking after children or running errands, which ensured not only their own survival and enabled them to learn different skills, but it ensured that one day they would be able to provide for their biological brothers and sisters far away and the family with whom they wanted to be reunited. They carefully selected from the local resources in their environment and took these opportunities to gain confidence and pride, minimising attention from their destitute and stigmatised position as orphans. As Ben explained with a cheeky smile, "*Meme*, if I chop wood and make money, it makes me feel good and takes away my headaches and I feel free and good again."

Dreams and the desire to go to school

Melody, in following her dream of becoming a nurse, expressed her concern about not going to school. She made a request for me to ask her aunt about the possibility of her and Melody going to school. This request opened a conversation where both expressed their desire to learn to read and write like all the school children they cooked for and looked after. Although this was a very valid and reasonable request, I immediately felt awkward because my initial agreement with their aunt, who granted me permission for them to participate in my research, was that I refrain from any discussions related to school. I was for the first time in a very tight ethical corner. I did not know how to answer them and knew I could not make any promises that I could not keep. However, this is one of the moments in the field in which, when confronted by various requests as Susan Levine (2013) describes, the anthropologist is unable to act at all, and is left uncomfortably sitting on the fence. The only answer that I could give them was to promise the girls that I would talk to their aunt,

recounting their good work and their ability to look after her sick family members and recommending that they could also perform such duties before and after school and during school holidays, as was the case for my school children participants who lived in a nearby village. Their desire to go to school indicated a key mode of social mobility promoted in the Village, and in Namibia more generally, through which orphaned girls understood they could improve their own circumstances. I did talk to the aunt, and she explained that she "was trying her utmost best" to get them into school. She felt pressure from the local government to send the children to school, but needed them to look after her dependents. When I left the field, the girls were still not in school.

In contrast to the girls, the two boys did not want to go to school and they expressed various reasons why they felt the school system would not benefit them. Ben, in his various arguments about his dislike for school, explained, "*Meme*, I am not from this area and the children know it, and for me at my age to start school, everybody would laugh at me." Strongman's refusal correspondingly related to him not being able to cope with the demands made in terms of schoolwork and also his fear of being an outsider. John Mushaandja and Diane Ashton (2013, 28) argue that the fear orphans have of being bullied and victimised is common and, during their research on the various challenges faced by orphans in Windhoek, orphans indicated that they did not want to attend school because they would find the integration into school too difficult. Furthermore, the study also found that school principals insisted that orphans paid school fees, although government policy exempted them from paying any hostel and school fees.

The payments made by the Namibian government in terms of grants to guardians amounted to NZ$10 or NZ$20 per month, we which barely covered the children's essential costs, and caregivers felt this made it even harder for orphans to be able attend school. According to a study about vulnerable children by Chiku Mnubi-Mchombu (2013, 209-290), children from the Ohangwena region were particularly in need of exemption from school fees from the development fund, financial assistance and child care support, and that they lacked the information necessary to ensure they received such support. In recent years, all primary school children have been subsidised and school fees, stationery and textbooks are free, to ensure that more children are able to go to school without any challenges (Shanyanana &

Cross, 2014). However, as my research shows, more attention needs to be directed to other non-monetary, social barriers that exist, and how the challenges that orphans and vulnerable children face in meeting more basic needs, such as food security, can prohibit school attendance.

Both Ben and Strongman wanted to join the workforce as soon as possible, and their desire to do so was influenced by various factors. For Strongman, it was his desire to follow in his grandfather's and father's footsteps, to go and work in the mines, revealing that being orphaned has not disconnected him from the gendered labour legacies of his biological kin. Strongman felt that he did not need any education because of the stories told by his grandfather of people in Namibia who became rich from working in the mines. He also wanted to work to support his other siblings and take full responsibility for them, being the eldest in the family. Again, this demonstrated that despite being orphaned and living with a new 'family', his previous kin roles and duties remained central to his identity and hopes. Ben, on the other hand, wanted to go and find his father's family, which would take him to the Namibian fisherman's town of Walvis Bay, where he thought he could earn some money. For both of them, the circumstances of being orphans made them focus on gaining financial independence, success and security, irrespective of their age and education.

Conclusion

Indirectly, the destruction of family units due to HIV/AIDS, the urban - rural flow of people, and new labour patterns, all contributed to the emergence of new family forms in Namibia that included orphans, but did so in ways that were based on precarity, a lack of trust and love, and resource interdependency, which tended towards exploitation. These circumstances, in turn, shaped the decisions the orphans made for their futures, as they carved out strategies, relationships and dreams for a better life in the years ahead and into adulthood. These futures were gendered ones, with girls seeking jobs that extended their caring roles into the workplace, and the boys hoping to utilise their growing business acumen to make their way into the industries of their fathers, in fishing and mining. In becoming their confidant and ally, I too became invested in their dreams and hopes, encouraging them to imagine these futures, and even becoming entangled in their tactics to

improve their opportunities, as the girls tried to influence their aunt through me, and the boys made use of the availability of my car to help to maximise their earnings.

A number of agents formed relationships of responsibility with the orphans, including myself, but these were tempered by a limited amount of influence over the children's lives and circumstances. I was thus unable to influence the aunt's decision about school attendance for Melody and Candy. Facing the urban drift of kin, the aunt had few choices of who could care for their increasingly sick dependents. Guardians received little support from the government to send orphans to school. The state could legislate that fees be waived for orphans attending school, but could not compel caregivers to allow them to attend and, despite such legislation, underfunded schools found it difficult to take or seek out orphans who could not pay any fees. Neighbours helped by offering odd jobs to orphans, but only sporadically, focusing their resources on their own often already strained households. Agency (in the form of responsibility) to care for these children was weakly distributed across a network that left no one empowered to do a careful and comprehensive job. In such circumstances, the children were left to largely care for themselves, and developed high degrees of autonomy. For my orphaned participants, their ability to look after themselves, as well as look after others and contribute to their households, was a source of self-worth and became the basis for imagining more empowered adult lives. My findings thus echo Lorena Gibson's (2011, 15) focus on "people's hope and agency" which "allows for a reading in terms of possibilities as well as success and failure".

CHAPTER TEN

Discussion and conclusion

For the children of rural northern Namibia, health and illness were a daily concern. This research set out to explore children's narratives and understandings of health and illness. The thesis engaged with theories of agency, childhood and health to identify children's multi-layered agency, which I have shown involved forms of hope, will, resistance, responsibility, citizenship, care and kinship as they sought to keep themselves and their families healthy in difficult circumstances. The children's narratives exposed how the young participants made sense of health and illness, expectations and demands and how they continually renegotiated the meaning of bodily suffering and wellbeing through different tactics and strategies. They made reflexive decisions about health and illness, in order to negotiate their own challenged situations and lives, which reflected their situatedness within particular biopolitical contexts, regimes of stigma and silence, transforming kinship structures, and socially constituted ways to hope for and imagine the future. Their stories were complemented by the methodological approach I employed, which allowed children to have both collective and individual space. The sensitive nature of their health and illness concerns therefore led me to different methodological strategies, including home visits, participant observation, photo elicitation, drawings, body mapping and free listing, in which the young participants had an opportunity to further express their individual views.

In Chapters Four and Five I showed that irrespective of what children are taught in schools, in the state's efforts to prepare them to be good biomedical citizens, huge differences exist between the realities theses children faced and the expectations placed upon them. The children tactically related to these challenges as they were taught through health science to wash hands in the absence of taps, running water or flushing toilets, and the different realities existing in their homesteads. The children in this study showed that they had the ability to cope with the realities of both worlds, but that the conflicts between them sometimes generated critique and resistance. As Chapter Five revealed, trying to stay healthy involved constantly negotiating their environment through the lens of dirt and

cleanliness, and their responsibilities to family members to keep domestic spaces clean with the limited resources they had to achieve this.

In Chapter Six I showed how the care provided by the participants for sick HIV positive family members was a complex process. Children had to become effective carers without full knowledge or understanding of their family members' health issues. Despite the secrecy and stigma surrounding HIV/AIDS, the children broke these silences through discussion with each other, and through photo voice with me. Despite an adult social rationale for secrecy and silence based on the desire to avoid familial and community stigma, the participants felt that openness and discussion would have helped them to cope better with HIV/AIDS deaths, revealing how the wellbeing needs of children and adults are not always aligned. Chapter Seven continued to discuss the children's care-giving relationships, arguing that they developed individual agency and personally meaningful identities through the process of care and responsibility that were deeply relationally constituted.

Chapters Eight and Nine turned to how, amidst the regular loss of parents and family members, some participants in this study navigated new lives with fellow orphans and within non-kin groups. It demonstrated the ways in which kinship and care for children are remade in the wake of illness and death, coupled with urbanisation and longstanding practices through which children circulated for labour. For orphaned children who did not reside with kin, whose lives were difficult and precarious, they showed that they did not simply accept their daily conditions and circumstances. Through their actions they built new relations that helped them to survive, turned daily chores and work into ways to build up skills and hopes for possible futures, and for the boys, accrued personal covert resources that would allow them choices. All the while they demonstrated their ability to maintain their own wellbeing and craft meaningful lives despite their socially stigmatised position.

These dynamic and agentive aspects of childhood are often ignored and overlooked by the local media that emphasises how modern childhood should involve the adult protection of innocence and formal education, and which focuses on agency vis-à-vis the rights of children. This approach is decontextualized from how children's lives are actually played out

in a country such as Namibia still battling with HIV/AIDS and other health challenges. It is also removed from the relational way in which agency actually unfolds in contexts where duty, responsibility, citizenship and care are as crucial to selfhood as individual rights.

This study did not only ethnographically observe this multilayered agency, but also fostered children's voices in particular ways. My research thus involved a participatory method that allowed and encouraged participants to express their perspectives, share personal stories, be respected for their silences and tactical avoidances of particular issues and topics, or have space to ask awkward questions that were socially taboo. This thesis was thus conducted from a particular political position, as through the methodological example set out in this project, I am arguing against the common treatment of children in Namibia as voiceless, and seek to provide a model for other ways children and childhood can be conceived and approached by those responsible for national issues of wealth and wellbeing.

The results of this research reveal that children are never passive or docile. They not only accompany sick family members to the hospital and local clinics, and act as mediators, but provide domestic care and biomedical monitoring. As a consequence, children should be included in discussions around health and illness at every medical and policy level, to better appreciate their everyday involvement and crucial roles, and their experiences of this care labour. With limited national health resources, the focus has understandably been focused on sick patients and not on the children who form part of the service delivery in the health system. But as this study has shown, while children are immensely resilient and proactive, there are likely ways that could better support them in providing care and in growing up in a healthy environment. As one practical example of how this might be done, the Namibian Children's Parliament could be a vital platform whereby children's concerns and experiences in the health system could be addressed and filtered through into policy formulations. Moreover, policy initiatives around health issues should be required to garner in depth children's perspectives as a matter of course.

There are numerous elements regarding children experiences of health and illness that this study could not address, but which the thesis reveals as worthy of future research. There is a need to investigate further the limits of children's care abilities. For example, in helping

their family members with their medication, does this ever fail, and what gaps exist in this informal system? Children in this study sustained hopes and dreams of futures that involved becoming doctors, nurses and teachers. It would be useful to follow children into early adulthood to see how /whether these care roles shape future work possibilities. A further study is also needed to see how school programmes might better accommodate children who are absent from schools while they are assisting sick family members attend local clinics and hospitals or even losing days from school due to their caring responsibilities extending overnight at home. Moreover, a serious medical investigation is needed into the health needs of children between nine and to twelve, currently missed by the government childhood health strategy.

Given my emphasis on children's voices, it is fitting for me to end with the words of one of my young participants. In this quote, Messy reveals the diverse ways in which, in the domain of health and illness, children's agency is deeply inter-relational, is tied up with modes of citizenship, care, duty and responsibility, can be defiant and cut against the grain of social norms and family wishes, and is always reaching past the present into an imagined future and hoped for social world: "Although we are poor and sometimes have little to eat our health and that of our families is important. Although it's hard and difficult to talk about illness, because that means death to me, I love being healthy because that means life."

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APPENDICES

Appendix A
Ethics approval from the University of Canterbury Human Ethics Committee

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2013/10

11 March 2013

Rosa Persendt
Anthropology Programme
UNIVERSITY OF CANTERBURY

Dear Rosa

The Human Ethics Committee advises that your research proposal "Children's understandings of health in Namibia" has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your revised application.

Best wishes for your project.

Yours sincerely

Lindsey MacDonald
Chair
University of Canterbury Human Ethics Committee

Appendix B
Extended ethics approval from the University of Canterbury Human Ethics Committee

13 November 2013

University of Canterbury
Human Ethics Committee

The Chairperson

Title of the project: A study of children's understandings of health and illness in Namibia. (Ref: HEC 2013/10).

I would like to thank you for my ethics approval dated the 11th March 2013.

I have just completed my first field research visit of five months in Namibia and will be returning in December for two months to complete my fieldwork.

Following the initial data analyses stage I have discovered gaps in the data which require further investigation. As this will involve a slight variation from my initial proposal, to include interviewing additional subjects in the project, I am requesting further approval from the human ethics committee.

For the initial stage of the research I was granted approval to interview children who are engaged in formal schooling. However, during my fieldwork it became apparent that not all children were in school. Some were required to be at home to provide care for family members or to work in the fields. I and my supervisors believe that it will be important to interview children who are not attending school or at least not regularly attending school and therefore are outside the normal learning environment.

In Namibia there is a dual medical system which incorporates both indigenous and western medicine. It is possible that the non-school children may have more knowledge of the indigenous medical system /beliefs than the school children. As we are asking "how" children learn about health and illness, and their source of their belief systems, then these non-school children need to be represented in the study.

The ethical process remains similar. The school children were selected with the assistance of the school headmaster who made initial contact with the children's families. The non-school children will be selected with the assistance of the members of the village council and in the first instance contacted by a representative of the council who will explain the project and ask if the researcher can contact them. For non-school children, as for those in school, parental permission is sought and all other previously approved ethical processes will be followed.

I intend to depart for my second field trip on the 8 December 2013.

Thank you for your consideration, I look forward to your reply.

Yours sincerely

Rosa Persendt

PhD student (78928426)

UNIVERSITY OF CANTERBURY

HUMAN ETHICS COMMITTEE

Secretary, Lynda Griffioen
Email: human-ethics@canterbury.ac.nz

Ref: HEC 2013/10

20 November 2013

Rosa Persendt
Anthropology Programme
UNIVERSITY OF CANTERBURY

Dear Rosa

Thank you for your request for an amendment to your research proposal "Children's understandings of health in Namibia" as outlined in your email dated 18 November 2013.

I am pleased to advise that this request has been considered and approved by the Human Ethics Committee.

Yours sincerely

Lindsey MacDonald
Chair, Human Ethics Committee

Appendix C
Ethics approval from the Ministry of Health and Social Services, Namibia

9-0/0001

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198 | Ministerial Building | Tel: (061) 2032562
Windhoek | Harvey Street | Fax: (061) 222558
Namibia | Windhoek | E-mail: hnangombe@mhss.gov.na
Enquiries: Ms. H. Nangombe | Ref: 17/3/3 | **Date:** 03 May 2013

OFFICE OF THE PERMANENT SECRETARY

Ms R.M Persendt
P.O. Box 6362
Christchurch
New Zealand

Dear Ms Presendt

Re: A study of children's understandings of health and illness in Namibia

1. Reference is made to your application to conduct the above-mentioned study.

2. The proposal has been evaluated and found to have merit.

3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**

3.1 The data to be collected must only be used for completion of your Doctor of Philosophy in Medical Anthropology;
3.2 No other data should be collected other than the data stated in the proposal,
3.3 No any other data collection method other than what is stated in the proposal should be employed in the field
3.4 No photos of children taken by the children or by the researcher should be published in any document;
3.5 A quarterly report to be submitted to the Ministry's Research Unit;
3.6 Preliminary findings to be submitted upon completion of study;
3.7 Final report to be submitted upon completion of the study;
3.8 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,

MR. ANDREW NDISHISHI
PERMANENT SECRETARY

" Health for All "

Appendix D
Consent form for children [English]

College of the Arts
School of Social and Political Sciences
University of Canterbury, Christchurch
New Zealand
Tel: + 64 3 364 2976
Fax:+64 3 364 2977

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

"Child Assent Form"

PhD thesis research by Rosa Persendt, 2013-2014

Children's understanding of health in Namibia

June 2013

I have been given a full explanation of this project in the language of my choice and have had opportunity to ask questions.

I understand what is required of me to take part in the research.

I understand that participation is voluntary and I may withdraw at any time without penalty. Withdrawal of participation will also include the withdrawal of any information I have provided should this remain practically achievable.

I understand that any information or opinions I provided will be kept confidential to the researcher and that any published or reported results will not identify me. I understand that that a thesis is a public document and will be available through the UC library.

I understand that all data collected for the study will be kept in locked and secure facilities and/or in protected password electronic form and will be destroyed after ten years.

I understand the risks and benefits associated with taking part and how they will be managed. I understand that I able to receive a report on the findings of the study through the researcher herself at the end of the project.

I understand that I can contact the researcher, Rosa Persendt at + 264 812840039 or supervisors Dr. Anne Scott, (+64 33 64 2987) Associate Prof. Pauline Barnett ,(+64 33 64 2987) and Dr. Catherine Trundle(+64 4721000) .If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch(human-ethics@canterbury.ac.nz) and Ms. Elizabeth Shaama from the Ministry of Health and Social Services, Namibia at (+264 61 2032510) for further information.

By signing below, I agree to participate in this research project.

.....	.....	.....
Name	Date	Signature
.....	.....	.....
Researcher	Date	Signature

Appendix E
Consent form for children [Oshiwambo]

College of the Arts
School of Social and Political Sciences
University of Canterbury, Christchurch
New Zealand
Tel: + 64 3 364 2976
Fax:+64 3 364 2977

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

June 2013

Omukanda woku yandja eoitikilo kudja kovakulunhu navatonateli vounona

PhD thesis research by Rosa Persendt, 2013-2014
Cell number: 0812840039
Eudoko lounona koundjolowele moNamibia

Ondapewa ehokololo liyadi lomapekaapeko Melaka eli handi udu nawa nonda kala nomhito yoku ninga omapulaapulo

Ondiuditeko aishe oyo nda teelela okuninga momapekaapeko .

Onda udako kutcha okukufa ombing aeliyambo na onatu dulu okuxulifapo ekufombing efimbo keshe ohaxulifapo.

Ondaudako nondina etwokume kutya omauyelele aa ndayandja oshiholekwa, oo itaakal fekelelwange nge a tulwa momushangwa. Ondina udite kutya omushangwa (thesis) omauyelele a keshe umwe woo otaukakala mobibilio yoshiputudilo shopambada

Ondina eudeko kutya omauyelele paembaatila ile pamahingula omapekaapeko aa atalikala wa amenekeka.

Ondina eudeko kombinga yomawi no mauwa onasha nekufombinga netonatelo lao .

Ondina eudeko kutya ohandikapewa oidjemo yomapekaapeko aa kuudilila komupekaapeki mwene nge ompekapeko axulu eshisha monika moma pekaapeko nge euya pexulilo.

Ondina eudeko kutya ohandi dulu okuninga ekwatafano nomupekaapeki Rosa Persendt at + 264 812840039 or supervisors Dr. Anne Scott, (+64 33 64 2987) Associate Prof. Pauline Barnett ,(+64 33 64 2987) and Dr. Catherine Trundle(+64 4721000) nongenge opena omakema keno handi dulu okukwatafana wo kakomittee ko the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch(human-ethics@canterbury.ac.nz) and Ms. Elizabeth Shaama from the Ethics committee, Ministry of Health and Social Services, Namibia at (+264 61 2032510) opo umone omauyele a wedwapo.

Okushaina pedu otashi ulike etwokuwe nokukufa ombinga momapkaapeko.

.....	.....	.....
Name	Date	Signature
.....	.....	.....
Researcher	Date	Signature

Appendix F
Consent form for parents and caregivers [English]

College of the Arts
School of Social and Political Sciences
University of Canterbury, Christchurch
New Zealand
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Fax:+64 3 364 2977

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

June 2013

CONSENT SHEET FOR PARENTS AND CAREGIVERS

PhD thesis research by Rosa Persendt, 2013-2014
Cell number: 0812840039
Children's understanding of health in Namibia

I have been given a full explanation of this project in the language of my choice and have had opportunity to ask questions.

I understand what is required of me and my child if I agree to let my child and myself take part in the research.

I understand that participation is voluntary and my child and I may withdraw at any time without penalty. Withdrawal of participation will also include the withdrawal of any information I or my child have provided should this remain practically achievable.

I understand that any information or opinions I or my child provided will be kept confidential to the researcher and that any published or reported results will not identify me or my child. I understand that that a thesis is a public document and will be available through the UC library.

I understand that all data collected for the study will be kept in locked and secure facilities and in protected password electronic form and will be destroyed after ten years.

I understand the risks and benefits associated with taking part and how they will be managed.
I understand that I able to receive a report on the findings of the study through the researcher herself at the end of the project.

I understand that I can contact the researcher, Rosa Persendt at + 264 812840039 or supervisors Dr. Anne Scott, (+64 33 64 2987) Associate Prof. Pauline Barnett ,(+64 33 64 2987) and Dr. Catherine Trundle(+64 4721000). If I have any complaints, I can contact the Chair of the University of Canterbury Human Ethics Committee, Private Bag 4800, Christchurch(human-ethics@canterbury.ac.nz) and Ms. Elizabeth Shaama from the Ethics committee, Ministry of Health and Social Services, Namibia at (+264 61 2032510) for further information. If you agree to participate in the study, you are asked to complete the consent form and I will come back to your house in 3 days to pick the form.

If you agree to participate in the study, you are asked to complete the consent form and I will first read the information letter and consent form particulars in a language comfortable to you, and leave the information and consent forms with you. I will then come and collect it after three days or a time convenient to you. As an alternative you will also be able to give vocal consent that will be recorded in order to keep a record.

By signing below, I agree to allow my child and myself to participate in this research project.

.....	.....	.....
Name	Date	Signature
.....	.....	.....
Researcher	Date	Signature

Appendix G
Information sheet for parents and caregivers

College of the Arts
School of Social and Political Sciences
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New Zealand
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Fax:+64 3 364 2977

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

INFORMATION SHEET FOR PARENTS AND CAREGIVERS
PhD thesis research by Rosa Persendt, 2013-2014
Cell number: 0812840039
Children's understanding of health in Namibia

Elalakano lomapekaapeko

Ohandi pekaapekaapeka eudeko lounona kombinga youndjolowele moNamibia Ondahala okupula ounana voumati noukadona ova velilongekida okupange omaliudo nomadiladila obo kombinga youndjolowele nouvela ohandi indile opo ove nokaana koye/ile omutekulu woye uninge vamwe womwaava handika ya navo meenghundafana .

Omulandu
Omapekaapeko teakaningwa moiluku ivali. Shotete okudja mu April fiyo September 2013noshitivali okudja mu Januali- Malitsa 2014. Tete ohandi kakala efimbo nokaana keshe pamwe novakuluntu vako peumbo lavo opo tushiivafane ame ndiyandje ouyelele womapekaapeko. Onatuka shakena meenhuundafana nakanona. mongulu yofikola pamwe omuvateli outaka fatulula nawa melaka lokaana.Ohandi kapula okaana omapulo opo ndiyeleke eshiivo lako eitavelo nomaliudo ako kombinga youndjolowele nomauvela, naashi onaku iwa ivanine omiti do pamutyuulukwakalo nodavangolo namavetelo aa hava pewa ngee towavele.

enghudafana nounona otadi kakala dili nomukalo wokudana, nounona otava ka faneka otwa kadanauko netanga, oinyandwa, okushanga, oiningwanima yefiku okufanekwa nefano (nomupekaapeki mwene opo takala). Eenghudafana nounona novakulunhu itadi kaningwa efimbo loilonga (yofikola ile yomeumbo).

Ovakuluntu onavaka pulwa kombinga yovaneumbo lavo noundjolowele wounona. Omapulo otaa kakwata oulefimbo wominute 20 lwaapo. Elaka eli hava udu nawa otali ka longifwa.

Omauwa nomawii

Omauwa ongaashi ounona otave ke lihonga kombinga yoilyolutuoukaume, okulitwa omukumo, qunongo, okufaneka nopena noku mbapeka, okulihonga oitya iipe, okunyola, okutunga oukaume, okulongifa efano nokukufa ombinga momapekaapeko .

Eenghatu tadi kakufwa

Omapekaapeko kaenasha nombuto yoHIV ndele oena nomauvela. Omukalo keshe otauka longifwa opo eenghundafana dikale daamenenwa pokati kovalikundi. Pakuhera eshiivo enghudafana onadi kakume oinima inasha noHIV nomauyelele oo otau kakwateka noukekea woo otauka amenwa. Ouyclele otaukanghabekelwa ashike pokati kavali (okaana nomupekaapeki). Omaudano oo aeke taakaningwa mongudu.

Nge okanona okauda nai efimbo lenghudafana eenghudafana otadi kaxulifwapo divadiva. Otapa kakala omuxungimwenyo (ina Asino) adja noshitopolwa moshipangelo onashikeuyamo ngee sha pumbiwa Keshe umwe okuna oufemba okulikufa meenghudana doo eenghundafana itadi futilwa, ounona otavakapewa vikulya molwaashi eenghundafana (itava kavelwa nande ombedi nowa manguluka okaxulifapo eenghundafana fimbo keshe. Keshe omukufimbinga oteshiningi pomukalo wokuliyamba.

Kapena nande edina lomnhu ile lehangano talika longifwa mehokololo omshangwa womapekaapeko. Omauyelele aeshe otaakakala aamenwa.

Omupekaapeki

Omupekaapeki o Rosa Persendt omuNamibia adja moWenduka. Otapopi oshiingilisha nOshimbulu.otakala nomufatululi welaka loshiiwambo Okwaningile nale omapekaapeko momdo 2011 nomkunda Onamvila . otakakala momukunda okudja Apiilili fiyo September 2013 nokudja vali muJanuali fiyo maalitsa 2014 otadulu okumonika konomola yongodi +264 812840039.

Otelihongele ondodo youndokotola University of Canterbury in Christchurch, New Zealand, omapekaapeko aa oshimwe shokuwanifapo chongo lang metonatelo la Dr. A. Scott, Assoc Prof. P. Barnett na Dr. Catherine Trundle(onomolayongodi +64 3 366 7001) otakudhulu yoo okudengelwa Ms. Esther Shamaa, +64 61 203 2510 oministeli wouhaku moNamibia. Aveshe vatumbulwa otava dulu okuyandja ouyelele ounasha nomapekaapeko aa.

Ethical approval
Epitiko olayandjwa kokakomitiye kedina University of Canterbury Human Ethics Committee. Epitiko limue oladja koMinisteli wouhaka Ethics Committee of the Republic of Namibia's nge ouna ehalo okukufa ombinga nomapekaapeko aa yadeka, ofooloma yokuyandja epitiko

OSHINYANGADALWA	OSHO HATU KA NINGA
Okufaneka	Fanekaneembapekakombingayoshikandoshaxuuninwakwali to velenangheewaliwuuditeomafanoamwenaakwatelemoeumboleni, ovaneumbo, ookaumenaavovafimanakuove .omafanoamweokombingayaavovekukwafelaeshiwali to vele nasho waninga u veluke.
Okufanekaomalutu	Otamuka longa oovavali. Tamufanekekesheumweolutulamukwaomombapilayakulanopaumwenefane kaosho to diladilashi li meniloye.
omafano	Oukfanekanomafanomomudingonokoweumboleniileponheleyoyekesheop opekuwapalela.
Okambokoididilikwayefiku	Shangeoinyangadalwayoyeyefikutamekaokudjaongulandeefiyoosheshikanan gaala.
Oinyandwa	Ovepamwenookaumekoyeotamukapulwa mu shangenokudutaoshinyandwashenivenekombingayonghandangalayeendoho tola nova hakulimomdingonokoweninongeehavakwafelengee mw aka kongaekwafokuvooinyandwaikwaootaidulu l kwatelemongheehamukwatelepoomaukoleleeni, onakuiwaneendjodi.
Omaudanonomatanga	Omaudano a yoolokataadanaukwanomatangameengudupandje.
Omusholondodowamangul uka	Shangnioityayayooloka tai tis ha kombingayouhaku.

Appendix H
Information sheet for children

Children's information sheet

Hello, my name is Rosa Persendt. I am a student and would like to invite you to take part in my study that deals with your understanding of being what you know and think about children's health.

If you choose to join us, then in the coming weeks different activities will give you the opportunity to tell me about yourself, different illnesses you know, what you feel when you are sick, what you do to get better, who you go to when you are sick, what you do to stay healthy and what you drink or eat to become better.

I will give you a list of fun activities and explain what we are going to do. You will have different activities to choose from and do not need to do all of the activities and may choose the ones you are the most comfortable with. We will come together for about twice a week for two hours after school and there will be breaks for you in between the activities. You can choose the days we will meet.

University of Canterbury Private Bag 4800, Christchurch 8140, New Zealand. **www.canterbury.ac.nz**

I hope you will enjoy talking to and you will not have to answer questions you feel uncomfortable with. We will also make sure to stop all activities if you feel too unhappy to keep going.

You can only join the study with the written permission of your parent or caregiver. You will also sign a your own special permission form.When I have received both signed permission forms you can take part in this study.

Appendix I
Invitation to children